Assessment of the multi-sectoral approach (MSA) to non-communicable Disease (NCD) prevention policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016

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DECLARATION

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DEDICATION

To all of you for the good will, faith and support which is greatly appreciated

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EXECUTIVE SUMMARY

Tobacco use is the world's leading preventable cause of illness and death and the most important risk factor for non-communicable diseases (NCDs), particularly cardiovascular and chronic respiratory diseases (heart attack, stroke, congestive obstructive pulmonary disease and lung cancer). A Multi-Sectoral Approach (MSA) in the context of health refers to actions of sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health-related outcomes or the determinants of health or health equity. The operational definition of evidence of MSA in this study is "involvement of any two or more sectors, one of which must be government". Engaging in multi-sectoral actions is done using three primary approaches: inter-sectoral action, healthy public policy and health in all policies. This study assessed NCDs prevention policies related to the WHO recommended "best-buy" interventions for NCDs prevention, in South Africa and in Togo, and investigated the use of MSA in the formulation and implementation of tobacco control policies. To address the five study objectives, the study generated data from a documentary review on NCDs prevention policies and interviewed 56 key informants in both countries (26 in South Africa and 30 in Togo) on the formulation and implementation of tobacco control policies. The study used mixed methods and developed a "Comprehensive Framework for Multi-Sectoral Approach to Health Policy" to analyse study data. The framework is built around four major constructs of context, content, stakeholders and strategies. Study results indicate policies addressing the major risk factors of NCDs namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity have been formulated and implemented in South Africa and in Togo, with all four risk factors addressed in South Africa and only 3 in Togo, where unhealthy diet is yet to be addressed. Further, there was evidence of use of MSA in policy making process although more in formulation than implementation. Both countries ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2005 and since then substantial efforts were made to pass comprehensive legislations on tobacco control, though these laws are not yet fully WHO FCTC compliant. The stakeholders involved in tobacco control policy formulation were more diverse,

proactive and dynamic in South Africa than in Togo whereas the strategies employed were more straightforward in Togo than in South Africa. The extent of understanding and use of MSA in both countries consisted of an inter-sectoral action for health whereby the health department strived to collaborate with other sectors within and outside the government. Consequently, information sharing was identified as the main outcome of the interactions between institutions and interest groups within and across three critical sectors of the state, namely: the public (government), private and civil society. This resulted in sub-optimal implementation of tobacco control policies in both countries. In South Africa, local expertise through several scientific publications from research and academic institutions and a strong political will initially from the post-apartheid government were the most important facilitating factors both at the policy formulation and implementation stages, and they were higher than the ratification of the WHO FCTC. Conversely, in Togo, the WHO FCTC was the leading facilitator of the use of MSA in tobacco control policy making process. In both countries, the tobacco industries have been the main barriers to the formulation and implementation of tobacco control policies, but they are stronger in SA than in Togo because of their reported contribution to country revenues and their ties with the ruling power, particularly during the apartheid era. In reference to the three approaches to engaging in MSA mentioned above, inter-sectoral action is at the beginning of a continuum of degrees of policy integration. Therefore, to improve the inter-sectoral understanding and use of MSA on tobacco control policies in SA and Togo, this study recommend to move from an inter-sectoral action for health led by the Health Department to a multi-sectoral approach-whole of government-to health, managed by a national multi-sectoral mechanism at the cabinet level, which will ultimately improve policy coherence across government and yield significant progress toward sound formulation and implementation of comprehensive tobacco control policies.

Key words: Multi-Sectoral Approach, Tobacco Control, Non-Communicable Diseases, Conceptual Frameworks, Health Policy Analysis, Sub-Saharan Africa.

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LIST OF ACRONYMS AND ABBREVIATIONS

AAC	Academic Advisory Committee
ACF	Advocacy Coalition Framework
AFD	Agence Française de Développement
ANPPA	Analysis of Non-communicable Diseases Prevention Policies in Africa
APHRC	African Population and Health Research Centre
ATCC	African Tobacco Control Consortium
CANSA	The Cancer Association of South Africa
CVD	Cardio-Vascular Disease
DFID	Department for International Development
ECOWAS	Economic Community of West African States
FCTC	Framework Convention on Tobacco Control
HPSR	Health Policy and Systems Research
HEIA	Health and Economic Impact Assessment
HIA	Health Impact Assessment
HSF	Heart and Stroke Foundation
IDRC	International Development Research Centre
MSA	Multi-Sectoral Approach
NCAS	National Council Against Smoking
NCD	Non-Communicable Diseases

SANHANES	South African National Health and Nutrition Examination Survey
SADEC	Southern African Development Community
SHSPH	School of Health Sciences and Public Health
STEPS	Survey STEPwise approach to Surveillance
UEMOA	Union Economique et Monétaire Ouest Africaine/Economic and Monetary Union of West African States
WHO	World Health Organisation

CHAPTER 1 BACKGROUND

1.1. Topic introduction

Non-communicable diseases (NCDs) pose a major public health problem threatening both social and economic development worldwide, particularly in low and middle-income countries.[1] The four major categories of NCDs are cardiovascular disease, cancer, chronic respiratory disease, and diabetes; which share four major behavioural risk factors namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. Among these modifiable risk factors, tobacco use is the world largest preventable cause of illness and death. It is considered as the most important risk factor for NCDs, particularly cardiovascular and chronic respiratory diseases (high blood pressure, congestive obstructive pulmonary disease and lung cancer).[1]

There are over 1.1 billion smokers in the world and cigarette smoking is the most common form of tobacco use worldwide. The World Health Organisation (WHO) estimates that tobacco kills nearly 7 million people each year, of which more than 600 000 are non-smokers dying from environmental tobacco smoke, also called environmental tobacco pollution, or second-hand smoke. If no action is taken, tobacco will kill approximately more than 8 million people every year by 2030, with more than 80% of these deaths attributed to inhabitants in low and middle-income countries.

In South Africa and in Togo, like most of Sub-Saharan African countries, NCDs continue to rise despite both countries' commitments as WHO Member States to implement effective interventions. This is due to increasing incomes urbanisation, changes in lifestyle and diet. The rise in prevalence of NCDs is also due to inadequate resource allocation within the government to prevent and control NCDs while attempts to control tobacco use are hampered by resistance from tobacco industries. Further, policies and programmes to control tobacco use require collaboration (through a process of cooperation, coordination or integration) from multiple sectors within and outside the health sectors. For this reason, Multi-Sectoral Approach (MSA) is a hallmark of the WHO Framework Convention on Tobacco Control.

Moreover, formulating and implementing policies to reduce NCDs risk factors remain complex and multifaceted; that is why legislation is important to reinforce such policies and

institutionalise NCDs control programmes. As stated by the WHO Tobacco Free Initiative, the following recent developments favoured the adoption of effective tobacco control policies in many countries, including South Africa and Togo:

- Abundant scientific evidence on the serious adverse effects of tobacco use on human health and the effectiveness of recommended legislation in support of tobacco control measures.
- The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) negotiations raised international understanding about tobacco control and galvanized the political will for action in many countries.
- Compelling research by the World Bank, the World Health Organization and academic experts have refuted economic arguments against tax increases and other legislative measures.
- Litigation has exposed the efforts of multinational tobacco companies to conceal the truth about tobacco use and to undermine public health efforts around the world.
- Civil society organizations from many countries in a worldwide network have mobilized support for strong legislative proposals.

It is against this context that this study used tobacco control policies as an entry point to assessing the multi-sectoral approach to NCDs prevention policies in South Africa and in Togo.

1.2. Problem statement and research questions

There are evidence-informed population based preventive measures to address the four shared modifiable risk factors of NCDs, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. However, the role of MSA in the development, implementation and impact evaluation of policies, strategies and plans remains unclear. There is some evidence of tobacco control in high-income countries although narrow in scope and setting.[2] Successful examples exist at sub-national level, mostly in well-defined settings such as schools and workplaces, but not in the general population.[2] In Africa, there is limited research in the field of health policy and systems. No systematic work has been published, which analyses NCDs

prevention policies in such settings.[3] This is because health policy and systems research, unlike biomedical research, requires a multidisciplinary approach and complex study designs to ensure credibility in the analysis.[4] Therefore, there is a need to tackle the NCDs epidemic by focusing on risk factors, understanding existing policies, roles of the various institutions and interest groups in reversing current trends. Such health policy analysis will yield insightful contributions by investigating extensively the use of MSA in formulating and implementing tobacco control policies in Togo and in South Africa. This research is also demand-driven and problem solving in line with paragraphs 33-36, 42-43 and 57-59 of the 2011 UN Political Declaration on the prevention and control of NCDs.[5] Moreover, recognizing prevention as the cornerstone of global response (paragraph 34) and acknowledging the need to foster MSA to health at all government levels to comprehensively and decisively address risk factors and underlying determinants of NCDs (paragraph 42).

Consequently, the study questions were described here aimed at answering the following key questions:

1. What NCD prevention policies exist in Togo and in South Africa?
2. How were these policies on NCD prevention formulated and implemented in both countries?
3. To what extent was MSA employed in the formulation and implementation of the tobacco control policies?
4. What are the perceived enablers and barriers to the use of the MSA in the formulation and implementation of the tobacco control policies?
5. What mechanisms can be employed in both countries for improving or reinforcing multi-sectorality in the area of tobacco control?

1.3. Research objectives

The study described here sought to assess the use of a multi-sectoral approach in the developing and implementing of policies on NCDs "best buy" interventions particularly on tobacco use. Specific study objectives were:

1. To assess NCDs prevention policies related to the NCDs "best buy" interventions in Togo and in South Africa.
2. To examine evidence of MSA in those policies using operational criteria for MSA in both countries.
3. To assess the extent of the use of MSA in formulating and implementing tobacco control policies in both countries.
4. To assess factors, facilitating or hindering the use of MSA in formulating and implementing tobacco control policies in both countries.
5. To make recommendations on improving MSA in reducing tobacco consumption and exposure to tobacco smoke in both countries

1.4. Significance of the study

An effective MSA may result in successful prevention of NCDs by addressing factors that impact the environment and shapes individual choices. The rationale of this study was not to test the appropriateness of MSA which is generally evaluated, but to contribute to the evidence on how it works or how it should be used simultaneously to reduce major NCDs risk factors as well as their upstream, midstream and downstream determinants. The expected theoretical significance of this study is contributing to a conceptual framework of NCDs prevention policy process analysis. Indeed, the study developed a Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis by assessing and comparing case studies of tobacco control policies in two different country settings. It was anticipated that the findings will reinforce World Health Organization's recommendations for multi-sectoral action for health in formulating and implementing effective NCD prevention policies in the context of Universal Health Coverage

1.5. Chapters' overview

This thesis is structured into six Chapters, including the introduction, followed by a literature review in Chapter 2. The third and fourth Chapters present the methods and findings of the study respectively. The fifth Chapter discusses the study findings. In the sixth and concluding Chapter the key findings are summarised and conclusions made before highlighting the contribution of the study to the existing body of knowledge and suggesting areas of further research.

CHAPTER 2 LITERATURE REVIEW

This Chapter is structured into six parts, including the analysis of the situation and response to NCDs in the first two parts, followed by the history of the use and control of tobacco in the third part. The fourth part discusses the empirical evidences for MSA. The fifth part presents the definition of the relevant terms and the last one introduces the conceptual framework of the study.

2.1. Burden of Non-Communicable Diseases and their risk factors

2.1.1. At global and regional levels

NCDs have become a major public health issue undermining social and economic development throughout the world, particularly in low and middle-income countries. Indeed, the WHO[6] determined that: (1) of the 56.4 million global deaths in 2014, 39.5 million, or 70%, were due to NCDs; (2) the most prominent NCDs are cardiovascular diseases (45% of all NCDs deaths), cancers (22%), chronic respiratory diseases (10%) and diabetes (4%); (3) more than 40% (17 million) of the global deaths due to NCDs were premature deaths before the age of 70 years; (4). Up to two thirds of these premature deaths are linked to four major behavioural risk factors namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol (5). Close to half of the deaths are linked to weak health systems unable to respond effectively and equitably to the needs of people with NCDs. In 2014, WHO[6] also estimates over 75% (30.7 million) of global deaths in low and middle-income countries are related to NCDs with about 48% of deaths occurring before the age of 70 and that the annual deaths from NCDs will increase to 55 million by 2030, if countries continue with "business as usual" policies and interventions. Among the four modifiable risk factors mentioned above, tobacco use is the world's leading preventable cause of death. There are over 1.1 billion smokers in the world and cigarette smoking is the most common form of tobacco use. The WHO estimates tobacco use kills nearly sept million people each year, of which more than 600 000 are non-smokers dying from inhalation of second hand smoke. The WHO also estimates that tobacco use is a risk factor for at least four of the eight

leading causes of death in the world, namely ischaemic heart disease, cerebrovascular disease, lower respiratory infections, and chronic obstructive pulmonary disease.[7] If no action is taken, tobacco will kill more than 8 million people every year by 2030, more than 80% of them among people living in low and middle income countries.

In Africa, the WHO[8] estimated 40% of deaths in 2015 were related to NCDs and this proportion will rise to 55% by 2025 if nothing is done to improve prevention and control. The STEPS surveys[1] conducted between 2008 and 2010 in WHO African regions revealed; very high tobacco use (up to 23% in some countries), average alcohol consumption (6.2 litres of pure alcohol per inhabitant per year), 67% of inactive people in some countries, and very low consumption of fruits and vegetables by the general population. STEPS surveys are nationally representative NCD risk factor surveys using similar tools and methodologies to allow comparisons across countries.

2.1.2. In Togo

In Togo, the WHO[8] estimated the total deaths due to NCDs in 2012 to be 19,000 (30% of total deaths) with almost 37% and 35% occurring in males and females under the age 70 years, respectively. The NCDs responsible for deaths in Togo are cardiovascular diseases (11%), cancers (4%), diabetes (2%), chronic respiratory diseases (1%) and others (12%). Unfortunately, these estimates have a high degree of uncertainty because they are not based on any national NCDs mortality data. The STEPS survey conducted in Togo in 2010 sampling 4,800 persons aged 15 to 64 years with 91% completeness rate, showed approximately 19%, 2.6%, 6.2%, and 15.4% of the sample population were hypertensive, diabetic, obese, and overweight, respectively.[9] In addition, 8.5% used tobacco, 13% were physically inactive and 9 in 10 ate less than 5 portions of fruits and/or vegetables during a week as recommended by the WHO. Table 1 shows the prevalence of the four modifiable risk factors by sex in Togo.

Table 1: Prevalence of the NCD risk factors by sex in Togo in 2012

Risk factors	Males	Females	Total
Current tobacco smoking (2011)	11.0%	2.0%	8.0%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	3.8	0.9	2.3
Raised blood pressure (2008)	33.3%	29.8%	31.5%
Obesity (2008)	2.8%	5.7%	4.3%

2.1.3. In South Africa

In South Africa, the WHO estimated a total of 608 000 deaths due to NCDs in 2012 (43% of total deaths) with almost 47% and 35% occurring in males and females under the age of 70 years, respectively. The NCDs responsible for these deaths in South Africa are cardiovascular diseases (18%), cancers (7%), diabetes (6%), chronic respiratory diseases (3%) and others (10%). Unfortunately, these estimates also have a high degree of uncertainty because they are not based on any national NCD mortality data. The first South African National Health and Nutrition

Examination Survey (SANHANES-1)[10] conducted in 2012 aimed to assess defined aspects of the health and nutritional status of South Africans with respect to the prevalence of NCDs (specifically cardiovascular disease, diabetes and hypertension) and their risk factors (diet, physical activity and tobacco use). Some of its findings from a sample of 8166 households with a completeness rate of 77.2% are the following: prevalence of hypertension: 31.8%, Diabetes: 9.5%, ever smoking tobacco: 20.8%, obesity: 24.9%, overweight: 22.45%. The most recent population based survey on NCDs in South Africa was the 2016 South African Health and Demographic Survey[11], which revealed improvement, between 1998 and 2016, of indicators related to tobacco use and obesity in both sexes, and to alcohol consumption in women, whereas indicators of other major risk factors of NCDs got worse as summarised in Table 2.

Table 2: Trends in the NCD risk factors between 1998 and 2016

NCD risk factors	1998	2016
Overweight & Obesity (%) of adults 15+ years		
Overweight adult men	20	28
Overweight adult women	27	37
Obese adult men	7	3
Obese adult women	29	21
Ever drank alcohol in adults: % 15+years		
Ever consumed alcohol: adult men	42	61
Ever consumed alcohol: adult women	74	26
Hypertension: Blood pressure >140/90mm Hg &/or on medication		
Prevalence of hypertension in adult men	13	44
Prevalence of hypertension in adult women	16	46
Smoking prevalence: % of adults & adolescents 15-19 years +		
Currently smoking: % adult men	42	37
Currently smoking: adult women	11	7

Adopted from: DOH; MRC; ORCMacro (2007). *South Africa Demographic & Health Survey.* Department of Health: Pretoria.

Table 3 shows the prevalence of the four modifiable risk factors by sex in South Africa based on data from global survey.[6]

Table 3: Prevalence of the NCD risk factors by sex in South Africa in 2012

Risk factors	Males	Females	Total
Current tobacco smoking (2012)	28.0%	8.0%	18.0%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	18.4	4.2	11.0
Raised blood pressure (2008)	35.2%	32.4%	33.7%
Obesity (2008)	21.0%	41.0%	31.3%

2.2. Measures used to address NCD and their risk factors

The international community and local governments have recognized the importance of NCDs and have taken concrete measures to address them through legislative frameworks, policies and strategies. The most recent one is the 2030 agenda for sustainable development adopted in September 2015 by Heads of State and Government. Goal N°3 of the Sustainable Development Goals is to "ensure healthy lives and promote well-being for all at all ages" and has the following five NCD-related targets:

- Target 3.4: By 2030, reduce by one third premature mortality from NCDs.
- Target 3.5: Strengthen the prevention and treatment of harmful use of alcohol.
- Target 3.a: Strengthen the implementation of the WHO FCTC in all countries.
- Target 3.b: Support the research and development of vaccines and medicines for NCDs that primarily affect developing countries.
- Target 3.8: By 2030, achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all".[12]

Other legislative frameworks, policies and strategies related to NCD prevention include:(1) WHO 2013-2020 Global NCD Action Plan[13]; (2) WHO Framework Convention on Tobacco Control (WHO FCTC)[14]; (3) Global Strategy on Diet, Physical Activity and Health[15]; and (4) Global and Regional Strategies to Reduce the Harmful Use of Alcohol.[16] These commitments and required actions on NCDs are also reflected in regional and global resolutions and declarations such as the Brazzaville Declaration on addressing non-communicable diseases[17]; the Nairobi Call to Action on closing the implementation gap in health promotion[18]; the Moscow Declaration on NCDs[13]; the 2011 United Nations High Level Political Declaration on NCDs[5]; the Rio Political Declaration on Social Determinants[2]; and the 2014 UN Outcome Document on NCDs.[19] In the 2014 UN Outcome Document on NCDs, governments made four time-bound commitments to set national targets and develop national multi-sectoral action plans by 2015 and to start reducing risk factors and strengthening health systems to respond by 2016. The WHO Global NCDs Action Plan 2013-2020 comprises a set of "best buys" interventions which, when

implemented collectively by Member States, international partners and WHO, will achieve the global target of a 25% reduction in premature mortality from NCDs by 2025. These interventions, summarised in Table 4, include population level measures to reduce the four common behavioural risk factors of tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol as well as health systems strengthening actions to respond effectively and equitably to the needs of people with NCDs.

Table 4: WHO recommended "best buys" interventions for NCD prevention and control

Tobacco use
• Tax increases on tobacco • Smoke-free indoor work places and public places • Health information and warnings about tobacco • Bans on advertising and promotion
Harmful use of alcohol
• Tax increases on alcoholic beverages • Comprehensive restrictions and bans on alcohol marketing • Restrictions on the availability of alcohol
Unhealthy diet and physical inactivity
• Salt reduction through mass media campaigns to reduce salt content in processes foods • Replacement of trans-fats with polyunsaturated fats • Public awareness program about diet and physical activity • Marketing of food and non-alcoholic beverages to children
Health systems strengthening measures
• Prevention of liver cancer through hepatitis B immunization • Prevention of cervical cancer through screening and treatment of pre-cancerous lesions • Multidrug therapy to individuals who have a heart attack or stroke and to persons with high risk of cardiovascular event in the next 10 years

2.3. Tobacco use and tobacco control policies

In the succeeding sections we will describe tobacco, its origin, its uses, reasons people use it, health risks associated with tobacco consumption, and the framing of the global response to tobacco use.

2.3.1. History of the use and control of tobacco

Tobacco is a leaf named Nicotiana tabacum by Botanist Linnaeus in 1753. It was probably cultivated for the first time in the Americas as early as 6000 BC. In about 1BC indigenous Americans smoked tobacco and/or used it for rituals and treatment (enemas). Among animals, only humans are known to use tobacco. Even the most browsing animals like goats or sheep do not touch a tobacco leaf. Scholars have categorized human uses of tobacco as primary, secondary, or tertiary.

- Smoking is the main human primary use of tobacco. There are five forms of smoke tobacco: cigarettes, cigars and cigarillos, bidis, pipe and nargilla. A cigarette is an engineered device (in form, shape, size, colour, aroma and combustibility) designed to deliver nicotine to the consumer, quickly, conveniently and comfortably; it is the most popular form of smoke tobacco. Cigars and cigarillos are generally handmade forms of smoke tobacco; they are less used than cigarettes and almost exclusively by men; they have a strong odour and are often used as status symbol for the rich, prominent and bandits. Bidis are self (home) made cigarillos. The pipe is one of the oldest styles of nicotine delivery, which is slowly going out of fashion, except among some indigenous people the elderly and elites. Lastly, nargilla also called “hookah or shisha” is a steamed tobacco smoking.
- Snuff and chew tobacco are the main secondary uses of tobacco. Snuff tobacco (dry or moist) is a pulverized tobacco with or without additives such as vegetable oil and sodium bicarbonate, pepper, cloves, or menthol; it can be inhaled (i.e. taken nasally like cocaine/crack), or taken orally (placed between the gum and cheek). Snuff use is widespread among the elderly in African communities where it is produced locally. Chew

(spit) tobacco could be coarse, compacted, or packed finely in shredded tobacco leaf with additives. The chewer continuously spits a stinky mixture of tobacco juice and saliva. It is common among indigenous societies and in rural areas.

- The tertiary use of tobacco is tobacco dust which has repellent and insecticidal effects against ectoparasites (e.g. jiggers, lice, fleas) and some plant pests. Indeed, dust extraction is effective organic pesticide of non-food plants, if sprinkled around the base of the plants (often mixed with black pepper and liquid soap in water or oil emulsion).

The pesticide and toxic effects of tobacco are due to nicotine, an alkaloid found in tobacco.

So why would humans consume a pesticide? The answer is because nicotine is: (1) psychoactive with effects comparable to those of cocaine, marijuana and heroin: euphoria, sudden alertness or apparent relaxation, due to increased dopamine flow, and raised heart beat and breathing rates; and (2) addictive and therefore, creates user dependency. In addition to nicotine, there are at least 40 carcinogens in tobacco leaf (eg nitrosamines) with serious adverse effects to health.

In summary:

- People use tobacco because they are unable to quit once they get used, and addiction to tobacco use leads to cancers, cardiovascular & chronic respiratory conditions, and a series of other adverse effects to health, and ultimately to premature deaths.
- The tobacco industry produces an addicting product with serious adverse health effects with the sole purpose of making money
- Tobacco is neither food, nor drink, fibre, nor timber.

Table 5 summarizes the history of the use and control of tobacco

Table 5: History of the use and control of tobacco[7]

Dates	Events
1560	Tobacco introduced to Africa from South America by Portuguese traders
1560	French diplomat in Portugal - Jean Nicot - introduced tobacco to France
1600s	Chinese philosopher Fang Yzhi pointed out that smoking scorches one's lung
1633	Turkey imposed death penalty for smoking. Japan Bans smoking to prevent fires
1753	Botanist Linnaeus named tobacco *Nicotiana tabacum*
1761	First study in UK of effects of tobacco. Snuff users warned of nasal cancers
1840-1902	World's major tobacco companies founded (Philip Morris,Imperial, British American Tobacco…) tobacco tax introduced, cigarette manufacturing machines developed
1915	Japan: Cancer was induced in laboratory animals using tobacco
1953	US tobacco executives meet to find a way to deal with recent scientific data
1960	US study finds that smoking increases risk of heart disease
1964	First US Surgeon General's report/ Smoking causes cancer
1979	US -The Freedom Organization for the Right to Enjoy Smoking Tobacco (FOREST) was formed
1981	JAPAN: published first report linking passive smoking and lung cancer in non-smoking wives of smokers
1988	First WHO report on the effects of smokeless tobacco issued
1988	First WHO World No Tobacco Day announced
1993	South Act 83 to prohibit or restrict smoking in public places
2001	Czech. Rep. Philip Morris released a report to government concluding that smokers save government money - by dying early
2003	WHO: Framework Convention on Tobacco Control (FCTC) adopted by world nations
2004	Ireland bans tobacco use at the workplace, pubs restaurants
2004	Uganda bans smoking in restaurants, bars and educational institutions
2005	WHO FCTC came into force using international law to reduce tobacco use
2008	WHO Tobacco Free Initiative published the first Global Status of the Tobacco Epidemic[7]

2.3.2. Tobacco control policies

The deadly harm of tobacco use is well supported by historical evidence, but concerted global efforts to reduce tobacco use through law and policy have developed more recently. A major milestone was achieved with the drafting and adoption of the WHO FCTC, which established a set of minimum guidelines for government-led actions to reduce tobacco use in countries. The WHO FCTC is the first and only treaty negotiated under the auspices of WHO. It was negotiated between 1999 and 2003, adopted by the World Health Assembly in 2003 and enforced as international law in February 2005.[14] Article 3 describes its objective and protocols as being "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke."

As an international law, the WHO FCTC obliges Parties to implement a range of tobacco control measures. The most important ones are measures to reduce demand such as price and tax measures (Article 6), measures protecting individuals from exposure to tobacco smoke (Article 8), measures to regulate the contents of tobacco products and product disclosures (Articles 9 and 10), packaging and labelling measures (Article 11), measures relating to education, communication, training and public awareness (Article 12), restrictions on tobacco advertising, promotion and sponsorship (Article 13) and measures concerning tobacco dependence and cessation (Article 14). Measures relating to reduction of the supply of tobacco products are also prominent and include measures to reduce illicit trade in tobacco products (Article 15), measures relating to sales to and by minors (Article 16) and the provision of support for alternative livelihoods for tobacco growers (Article 17).

The WHO FCTC reflects the collaboration needed among countries to counteract the globalization of tobacco industry promotional practices with cross-border effects. Since 2015, the FCTC has achieved the highest recognition in health policy research worldwide. About 180 parties (179 countries and the European Union) have ratified the convention, including 44 African countries, despite interference of the tobacco industry to frustrate ratification efforts.

South Africa signed the WHO FCTC on June 16, 2003 and ratified it on April 19, 2005, whereas Togo signed in May 12, 2004 and ratified in November 15, 2005. Implementation in many countries, including South Africa and Togo consists of: (1) mobilizing resources and building capacity to influence policy change; (2) enforcement of tobacco control laws; (3) monitoring the tobacco industry manoeuvres to undermine or subvert tobacco control efforts; and (4) fighting illicit tobacco trade.

Tobacco is the only legalized substance that kills half of its users prematurely; therefore, it is in public health's interest to deglamourize and control tobacco use. Countries that stop tobacco use will prevent this generation and future generations from preventable death.

2.4. Empirical evidences on multi-sectoral approach

The need and call for multi-sectoral approach is neither new nor unique to health policy since it has been applied in several public policy fields such as environmental protection, emergency management, land use planning, and education policy.[20],[21] Indeed, previous findings from public administration on "collaborative governance" applying multi-sectoral approaches in public policies emphasized the importance of the institutional environment[22],[23], leadership[23], trust[24], analysis of networks[25], agreement on problem definition[26], and fostering the ability to manage conflicts.[27].

A multi-sectoral approach (MSA) in the context of health refers to actions of sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health-related outcomes or the determinants of health or health equity.[28] These include actions within and between sectors, at the local, regional, provincial, national, and global levels, needed to influence the social and economic landscape that enables the health and well-being of the population. Given the importance of the social determinants of health, policies that address them are considered the most promising approach to promote health and achieve sustainable health outcomes.[29],[30] These policies aim to integrate a systematic consideration of health concerns into all other sector's routine policy processes.[31] In the literature, such integrated policies are termed multi-sectoral approaches for health[31], whole-of-government approaches[32], governance for health[33] policies for better health[34] or integrated public health policy.[35]

The call for MSA in the health sector started in 1978 with the Declaration of Alma Ata, which stated upfront that realizing the right to health is a "social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".[36] Since then, engaging in multi-sectoral actions is done using three primary approaches[29]: Inter-Sectoral Action, Healthy Public Policy and Health in All Policies. Inter-Sectoral Action, proposed by the Alma Ata Declaration[36], involves efforts by the health sector to collaborate with other public policy sectors to improve health outcomes. The Ottawa Charter[37] introduced Healthy Public Policy, which involves an explicit concern for health in all areas of public policy through accountability for health impact. Health in All Policies[38], a major theme during the Finnish Presidency of the European Union, is defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity".

Nevertheless, the health sector in most countries focuses mainly on health care services and rarely on social determinants of health. Consequently, the potential of multi-sectoral collaboration (within government sectors or between the government, private and civil society sectors) remains untapped, particularly in many low and middle-income countries. Interestingly, evidence from public administration on "collaborative governance" in high income countries and on strengthening public sector capacity in low- and middle-income countries provides useful theories and lessons mitigating some challenges in successfully implementing MSAs to health in these settings.[39],[40],[41]

2.5. Theoretical basis: conceptual frameworks

Public policy emerges from the interplay between institutions, interests and ideas.[42] Health policy is a subset of public policy and can be understood as the courses of action (and inaction) that affect the sets of institutions, organizations, services and funding arrangements of the health system[43]. Health policy determinants are the outcomes of actions within and between sectors, at the local, regional, provincial, national and global levels, that influence the social and economic landscape, which in turn influences the population's health and well-being. The study of these determinants requires a multi-disciplinary approach to public policy making, and therefore aims

to explain interactions between institutions, interests and ideas in the policy process.[43] Frameworks and theories are key approaches to understand these dynamics. Frameworks help organize inquiry by identifying elements and the relationships among elements that need to be considered for theory generation; they do not, of themselves, explain or predict behaviour and outcomes.[44]Theories are more specific than frameworks, and postulate precise relationships among variables that can be tested or evaluated empirically.[44]

The study described here uses two categories of frameworks and theories: the NCDs prevention framework to discuss the relationships between individual and environmental factors known to contribute to the occurrence of NCDs, and the health policy analysis frameworks and theories to discuss and select the most suitable framework for empirical analysis of the study data. Before presenting these frameworks, this section starts with the definition of the relevant terms.

2.5.1. Definition of concepts/terms

2.5.1.1. Terms related to tobacco control

Below are definitions of some key terms related to tobacco control and NCDs used in this thesis. Most of them are extracted from the WHO (FCTC)[14]:

1. **Tobacco control** means a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke.
2. **Tobacco products** means products entirely or partly made of the tobacco leaf as raw material, which are manufactured to be used for smoking, sucking, chewing or snuffing.
3. **Smokeless tobacco** is any tobacco product used by humans in a way other than smoking (by chewing, snorting and dipping).
4. **Environmental tobacco smoke** also called **environmental tobacco pollution**, or **second-hand smoke**, is the totality of the products of combustion of a tobacco product (leaf, cigarettes, cigars, pipe, shisha, etc…) found in the air around a smoker. Inhalation of environmental tobacco smoke is also known as passive smoking.

5. **Tobacco industry** refers to tobacco manufacturers, wholesale distributors and/or importers of tobacco products.
6. **Tobacco advertising and promotion** refers to any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly, and;
7. **Tobacco sponsorship** means any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

2.5.1.2. Terms related to Health Policy and Systems Research

Below are definitions of the key terms related to health policy and systems research used in this thesis. Most of them are extracted from the methodology reader on health policy and systems research.[45]

1. **Health Policy and Systems Research (HPSR)** is defined as a field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy formulation and implementation processes to contribute to policy outcomes. By its nature, health policy and systems research is interdisciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that draws a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape− and be shaped by − health systems and the broader determinants of health. Some of the key characteristics of the health policy and systems research include the following: i) it encompasses research on or of policy, which means that it is concerned with how policies are developed and implemented and the influence that policy actors have over policy outcome (it addresses the politics of health systems and health system strengthening), and ii) it promotes work that explicitly seeks to influence policy, that is, research for policy. Health systems, health system development or strengthening, health policy, and health policy analysis are the four central elements in health policy and systems research.

2. **Health System**: a health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.[46] Roemer defines **health system** as a combination of resources, organization, financing and management that culminate in the delivery of health services to the population.[47]
3. **Health system strengthening** is defined as building capacity in critical components of the health system to achieve more equitable and sustained improvements across health services and health outcomes.[46]
4. **Policy** is a broad statement of goals, objectives and means that create the framework for activity. It often takes the form of explicit written documents, but may also be implicit or unwritten. **Policy** is also defined as a product of the interplay between institutions, interests and ideas.[42]
5. **Health policy** can be understood as the courses of action (and inaction) that affect the sets of institutions, organizations, services and funding arrangements of the health system. It includes policies made in the public sector (by government) as well as policies in the private sector.[43]
6. **Health policy analysis** as a multi-disciplinary approach to public policy aims to explain the interaction between institutions, interests and ideas in the policy process.[43] It can be conducted from three perspectives[43]: (1) an epidemiological analysis that identifies risk factors for particular diseases and the important targets for health interventions; (2) a cost effectiveness analysis that identifies which of several possible interventions to address a particular health problem provides the best value for money; and (3) a political and organizational approach to policy analysis that sees policy itself as a process - the process of decision-making - rather than focusing only on policy as the process output or management input.
7. **Policy initiator:** an individual, group, organization or group of organizations that act in the agenda-setting stage of the policy process.[48]
8. **Policy actor:** an individual, group, organization or group of organizations that act in the subsequent stages of the policy process.[48]

9. **Policy goals:** Situations, which initiators and actors find important and think they can stimulate or want to achieve.[48]
10. **Policy instruments:** The resources that initiators and actors can use to achieve the various predefined goals. They can be of three types: a) communication (e.g. health education), b) economic (e.g. price mechanisms) and c) legal (e.g. covenants and laws).[48]
11. **Determinants:** The causal factor policies intend to address to improve health and health-related behaviours. These factors could be health-related individual (e.g. motivation) or environmental determinants (e.g. social and physical factors).[49]
12. **Social Determinants of Health** are the circumstances, in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.[31]
13. **Multi-Sectoral Approach** in the context of health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health-related outcomes or the determinants of health or health equity.[50]
14. **Assessment** is a formal process of evaluation of a process or system, preferably quantitative, but sometimes necessarily qualitative.[51]
15. **Governance** is the complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations, and mediate their differences.[51]
16. **Interagency arrangement** is a formal (i.e. politically mandated) relationships between more than two sectors (i.e. a section of government that deals exclusively with a specific issue such as health, justice or agriculture).[52]

2.5.2. Non-communicable disease prevention framework

The concept of the four by four NCD prevention framework refers to the fact that the four major NCDs namely cardiovascular diseases, cancers, chronic respiratory diseases and diabetes share four major behavioural risk factors, which are tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. However, these individual factors should not belie the role of environmental factors such as working conditions, air pollution, transport networks, poverty, tobacco marketing and the relative prices of healthy and processes foods. To understand the relationships between individual and environmental factors known to contribute to the occurrence of NCDs, this study referred to the framework developed by the African Population and Health Research Centre to illustrate the occurrence of different types of cardiovascular diseases such as heart disease, stroke and others. It could be inferred from the framework presented in Figure 1 that addressing NCDs and their risk factors should be relevant to addressing socio-economic development factors by sectors outside health particularly in developing countries.

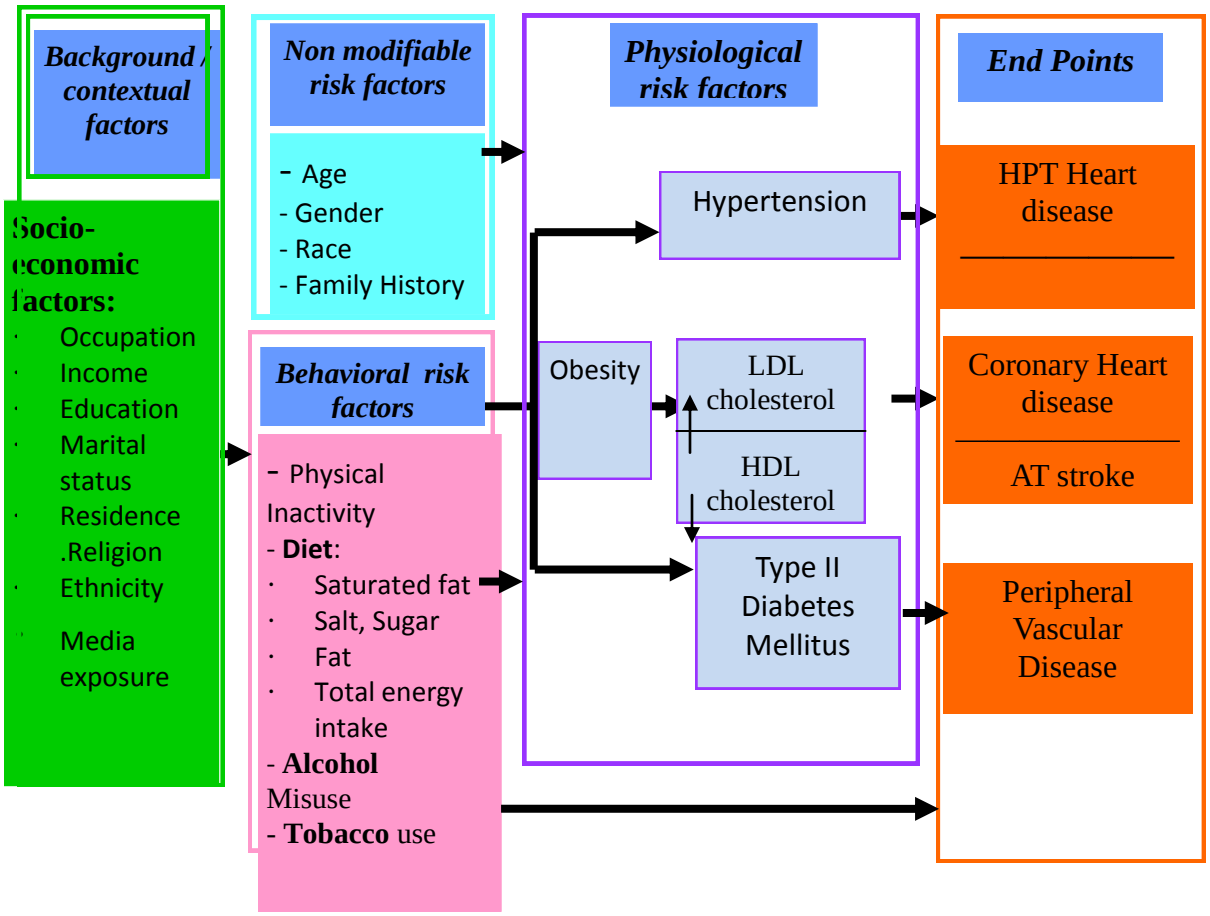

Figure 1 presents Cardio-Vascular Diseases (CVD) Prevention Framework

(Adapted from APHRC, 2014)

2.5.3. Health policy analysis frameworks

Scholars have proposed many frameworks and theories to help researchers organize and focus their efforts to analyse the policy making process. From a narrative synthesis review, this study identified eight frameworks and four theories with multiple major constructs that have been used for health policy. The key characteristics, strengths and limitations of each of them are described below.

2.5.3.1. Stages Heuristic Framework

With its four sequential stages of agenda setting, policy formulation, implementation, and evaluation, this framework is useful as a simple way of thinking about the entire public policy process. It helps researchers situate their study within a wider framework. The stages heuristic is suitable for contingency planning in disease outbreak such as Ebola wherein a problem is identified, severity acknowledged, and solution developed, implemented and monitored. However, its limitations are that it presumes linearity to the public policy process that does not exist and it postulates neat demarcations between stages that are blurred in practice.

2.5.3.2. Policy Triangle Framework

The policy triangle was specifically developed for health by Walt & Gilson (1994)[53] and it focuses on content, context, process and actors as depicted in Figure 2. The policy triangle acknowledges the incremental, but non-linearity nature of policy making and helps to explore systematically the somewhat neglected place of politics in health policy and can be applied to high, middle and low-income countries. It has been used for analysis for policy formulation on health issues such as mental health, health sector reform, tuberculosis, reproductive health and antenatal syphilis control.[4454] However, as argued by Howlett[55] the policy triangle pays too little attention to other factors that explain why and how policies change. For instance, the interplay between ideas, institutions and interests, the equity lens and the patterns of interactions between the health sector and other sectors in changing policy are not well addressed in this policy triangle framework. Walt and Gilson themselves recognised that their framework is not explanatory enough in the sense that it tends to produce analysis, which are very descriptive and do not provide insight into the drivers of the policy process.[44]

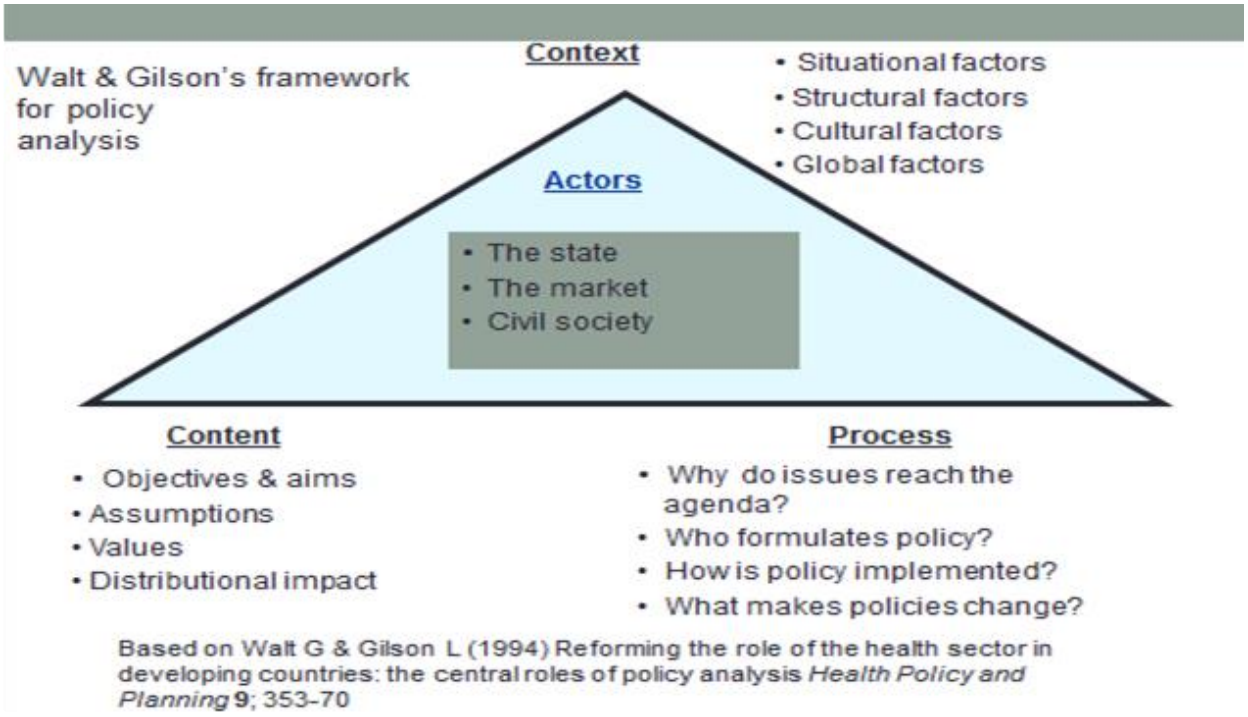

Figure 2 presents the Policy Triangle Framework
(Source: APHRC, 2014*)*

2.5.3.3. Health in All Policies Framework

The Health in All Policies framework was developed by McQueen and others (2012).[56] It aims to integrate a systematic consideration of health concerns into all other sectors' routine policy processes, and to identify approaches and opportunities to promote better quality of life. It refers to formal, sustained, "whole-of-government" (cross-sectoral and coordinated) policy initiatives aiming to improve population health. A Health in All Policies approach makes formal and sustained use of structures, mechanisms, and actions that are managed mainly outside the health care sector to improve population health and reduce health inequities across social groups. To analyse the findings of a realist-informed scoping review of the literature, Shankardass and colleagues[57], developed an adapted version of the McQueen framework. That adapted version includes three major constructs as described below and depicted in Figure 3: initiation context, implementation mechanisms, and intervention design.

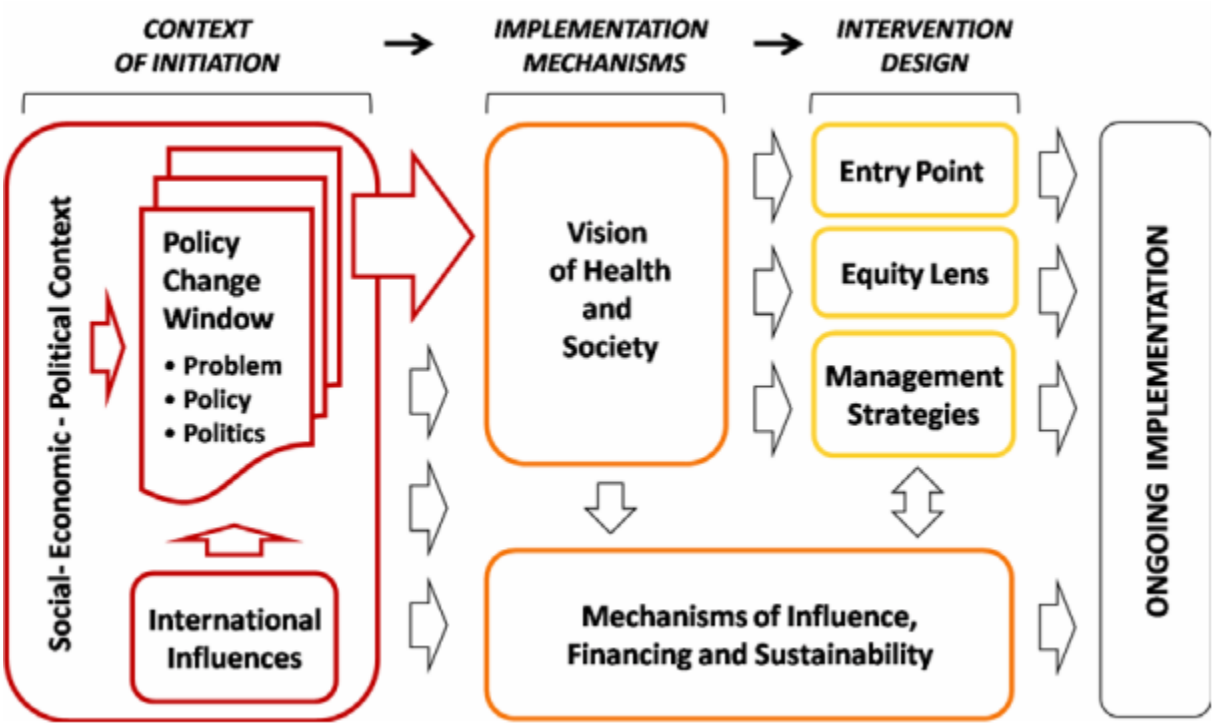

Figure 3 depicts the Conceptual Framework of the Getting Started with "Health in All Policies" (*Source:* Shankardass *et al.*, 2011*)*

- **Context of initiation**.

It includes social, economic, political, historical, and external influences that create policy windows and environment conducive for inter-sectoral engagement around Health in All Policies approach. The initiation of a government-wide Health in All Policies approach occurs in a "policy change window", based on Kingdon's notion (1984)[58] of "windows of opportunity" for policy change. Initiation is conditioned by three analytically distinct policy-making streams, and a window of opportunity is opened for a major policy change only if these three different streams of policy-making coexist simultaneously in a manner that is conducive in a "Health in All Policies" approach. These streams are: the "problem stream" (i.e. whether a problem is defined

and brought to the political agenda in a way that would require a government-wide policy solution like Health in All Policies), the "policy stream" (i.e. how and whether a variety of actors influence the design of feasible and sustainable policy options), and the "political stream" (i.e. how and whether politically agreeable policies are adopted). These streams may be coupled with chance political factors such as elections, or chance organizational cycle factors such as staff turnover, or by the actions of individual policy entrepreneurs who facilitate the coupling process by investing their own personal resources (e.g. reputation/status). As depicted in Figure 4, at certain junctures the streams merge, and in their confluence windows of opportunity emerge and governments decide to act.

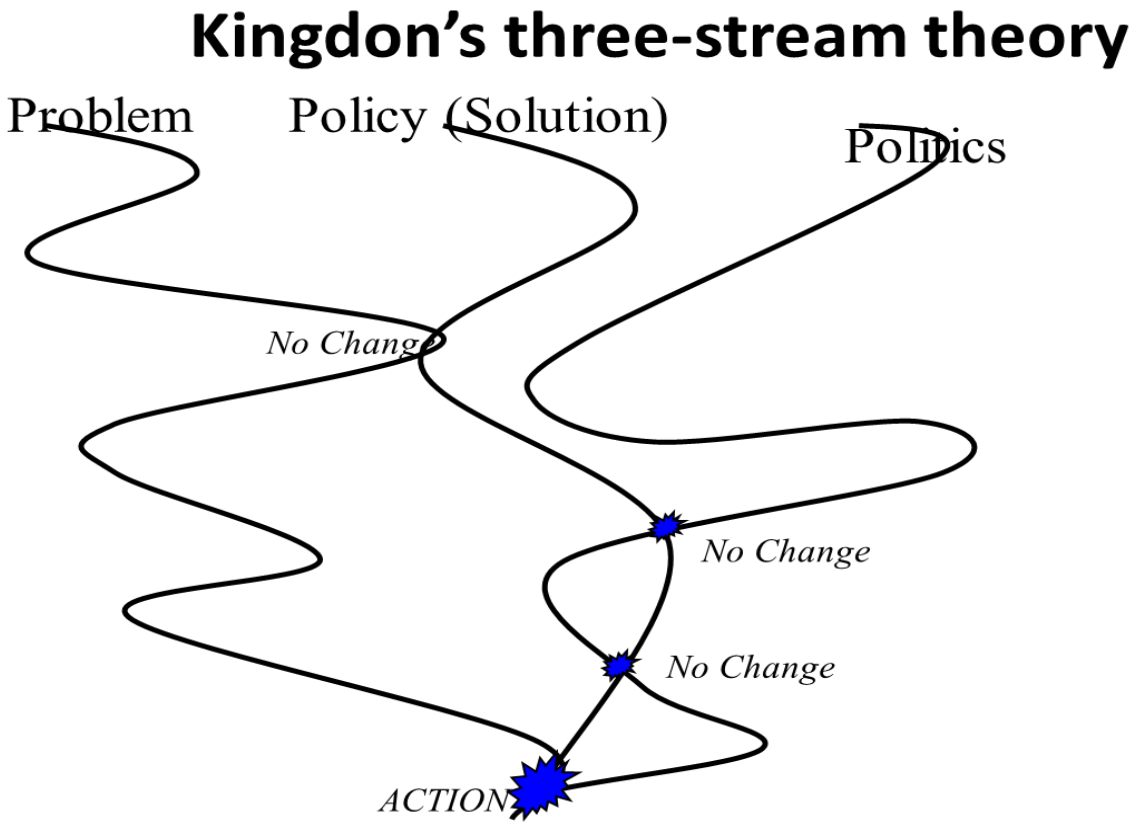

Figure 4 shows the Kingdon's three-stream theory
(Source: APHRC, 2014*)*

The policy change window is embedded within a distinct social, economic, and political context, and may be partly determined by international influences. These contextual factors continue to influence the implementation of the Health in All Policies approach beyond the initiation stage.

- Implementation mechanisms.

"Health in All Policies" implies coordination of programs across sectors and has implications for the autonomy of participating government sectors. This major construct includes mechanisms of influence, financing, and sustainability that facilitate sharing of power and control over decision making. It also includes participants' overarching interpretations of the ideas of "health", "society", and their interpretation of the relationships between these ideas.

- Intervention design.

"Health in All Policies" is defined by: i) the entry points selected for action to reduce health inequities vis-à-vis previously identified problem streams; ii) the equity lens of action, including the level of health determinants being addressed (i.e. upstream, midstream, downstream), the coverage of populations by action (i.e. focus on horizontal/universal or vertical/targeted approaches to reducing inequities), and implicit or explicit equity goals (i.e. closing gaps, flattening gradients, or improving the health of vulnerable groups); and iii) options available for managing and controlling interventions.

- Ongoing implementation

Intervention design should not be an endpoint of the Health in All Policies framework or the Multi-Sectoral Approach in the context of health; the approach is better understood as cyclical and iterative. The design of new interventions to reduce health inequities across diverse sectors may contribute in reshaping the initiation context (e.g. policy windows) and other factors in the framework over time (e.g. mechanisms for decision-making and interpretations of problem/action streams). This iterative character of the process has implications for the sustainability of the Health in All Policies approach over the longer term.

Table 6 presents the key parameters used by Shankardass and colleagues to operationalize the three major constructs of the framework.

Table 6: Key parameters of the three core domains of the Health in All Policies conceptual framework.[59]

	Constructs	Parameters	Assumptions or Definitions
1	**Context of initiation**	Relevance of welfare state profile	1. Countries featuring stronger welfare state profile may be liable to amenable government actions for health equity 2. Countries with high income and increasing labour market egalitarianism may have better heath outcome
		Timing, historical context and duration	Start dates and duration of health in all policies approaches in case countries
		International influences	Global initiatives that influence national policy agendas and priorities
2	**Implementation mechanisms (for facilitating coordination of programs and policies across government)**	Vision of health and society	Extent to which the visions held by the health sector, by other sectors and by the ruling party are complementary, comprehensive and coherent
		Patterns of interaction between health care and other sectors	Anticipated four patterns of relationships observable between sectors of government (and/or between government and non-governmental organisations) as described by Shankardass and colleagues.[59]: Information Sharing, Cooperation, Coordination or Integration.
		Government tools and structures	What tools and structures of government facilitate patterns of interaction conducive to health in all policies?
3	**Interventions design (for improving health equity through a "Health in All Policies" approach)**	Entry point	Inequity problem or health determinant that ends up being identified and acted on through one or more interventions
		Equity Lens	1. Type of interventions (upstream, midstream, or downstream) 2. Population level coverage of the interventions (universal or targeted) 3. Implicit or explicit equity goals based on the three options described by Whitehead and al.[60]: - Improve the health of vulnerable groups - reduce health gaps between most and least vulnerable groups, or - Flatten the social gradient in health across the entire population
		Management strategies	1. Health in all policies linked to the management and delivery of primary health care whose objectives include addressing social determinants of health. 2. Stand-alone health in all policies approach managed by an intersect of oral governance structure at local, regional and national level

In summary, the health in all policies framework is appropriate for the analysis of policies particularly assessing the influence of institutions and interest's groups integrating a multi-sectoral action for a specific health concern into the polices of other relevant sectors. For instance, it can be used for policy making on NCDs prevention measures. However, it lacks identification of stakeholders or assessment of how they engage in policy application.

2.5.3.4. Other health policy analysis frameworks identified in the literature

The Stages Heuristic, the Policy Triangle and the Health-in-All-Policies frameworks described above are the most used frameworks. Scholars have developed and used other frameworks often to complement these common ones, such as:

1. Policy networks[61]: This framework has a narrow scope with more focus on policy implementation; it is useful for improving the definition of elements and indicators related to policy implementation while using a more comprehensive framework for policy analysis. Few empirical studies in health in developing countries have used networks analysis as a lens.[62]
2. Collins framework[63]: The Collins framework has a narrow scope with more focus on policy content; thereby it is useful for improving the definition of elements and indicators related to policy content while using a more comprehensive framework for policy analysis.
3. The 'Advocacy Coalition Framework[64] (ACF) :

   Coalitions are groups of individuals and organizations with shared values, beliefs and resources. They cut across 'central' versus 'street level' distinction and are defined by their ideas (rather than self-interest). Policy brokers bring together coalitions and use the ACF to try to reduce disagreements between coalitions, by understanding and explaining their beliefs and policy change. The Advocacy Coalition Framework fits more in analysing policy-making in the energy and environmental sectors; although some of its construct elements could help in health policy dialogue towards formulating sound policies in the health sector.

4. Shiffman and Smith's Priority Setting Framework[65]

This framework complements the constructs of the policy triangle by giving more space for consideration of ideas and issue characteristics: institutions are perceived as part of actor power. However, it may neglect the importance and strategies of the institutions and interest groups in multi-sectoral approach to policy making.

5. Howlett and colleagues (2009) framework[55]

The Howlett framework's scope is narrow with more focus on institutions and interest groups. It complements the constructs of the policy triangle by insisting on the importance of knowing the power of the ideas to influence the ideas of the power in the policy making process.

6. Kingdon's Multiple-Streams Theory[66]

This framework' scope is also limited to policy context, reason why it is embedded into the framework for health in all policy. Otherwise, by arguing for the independence of the three streams and the need for them to be merged, the approach creates windows of opportunities allowing governments to act. Kingdon's theory emphasizes the need for researchers, policy makers and policy entrepreneurs to see policy both as an output and a process of decision-making. It exhorts them to be proactive and alert vis a vis the politics stream.

7. Punctuated Equilibrium Theory[67]

By arguing that the policy process is constituted both by stability and change, rather than one or the other alone, the Baumgartner and Jones' theory (like Kingdon's Multiple Streams Theory) exhorts researchers, policy makers and policy entrepreneurs to be proactive and alert because the prevailing policy image may be challenged and the monopoly power of the policy venue may face competitions. However, its scope is limited to policy formulation.

8. The 'Top-Down' Multiple Implementation Theory[68]: It has a narrow scope with a focus on policy implementation, thereby it is useful to improve the definition of elements and indicators related to policy implementation while using a more comprehensive framework for policy analysis.

9. The 'Bottom-Up' Multiple Implementation Theory[69]: This theory has a narrow scope with a focus on policy implementation, thereby it is useful to improve the definition of elements and indicators related to policy implementation while using a more comprehensive framework for policy analysis

In addition to their key characteristics, strengths and limitations described above, the constructs and variables of the frameworks and theories identified from a narrative synthesis review are depicted in Table 7.

Table 7: Constructs of key frameworks and theories of the public policy process that apply to health policy analysis.

N°	Theoretical frameworks	Constructs	Variables
1	Policy 'Stages' Heuristic[70],[71]	(1) Problem recognition and agenda setting (2) Policy formulation, (3) Policy implementation (4) Policy evaluation	(1) Issue search, issue filtration, issue definition, forecasting (2) Objectives setting, options analysis (3) Implementation (4) Evaluation, succession /termination
2	Policy triangle (Walt and Gilson 1994)[53]	(1) Content (2) Actors (3) Context (4) Process	(1) Objectives and aims, assumptions, values, distributional impact (2) The state, the market, civil society (3) Situational factors, structural factors, cultural factors, global factors (4) Why do issues reach the agenda? Who formulate policy? How is policy implemented? What makes policies change?
3	Health in All Policies Framework (Shankardass K et al. 2012)[57]	(1) Context of initiation (2) Implementation mechanisms (3) Interventions design	(1)(a) Social, economic and political context (relevance of welfare profile, timing, historical context & duration); (b) Policy change window; (c) International influences (2) (a) Vision of health and society; (b) Patterns of interaction between health care and other sectors; (c) Government tools and structures (3) (a) Entry point; b) Equity lens; (c) Management styles
4	Policy networks (Marsh & Rhodes , 1992)[61]	Policy community (tight-knit networks with few participants who share basic values and share resources) Issue networks (brings together many different groups and individuals for a common purpose or cause, and may have little continuity in values or participation)	Network analysis reflects the phenomenon of shared decision-making and exchange of resources, among groups and individuals of an issue network, to achieve their goals.

N°	Theoretical frameworks	Constructs	Variables
5	Collins framework (2004)[63]	Steps for public policy content analysis	(1) Define the context; (2) State the problem; (3) Search for evidence; (4) Consider different policy options; (5) Project the outcomes; (6) Apply evaluative criteria; (7) Weigh the outcomes; and (8) Make the decision.
6	The 'Advocacy Coalition Framework[64]	(1) Relatively stable parameters (2) External (system events) (3)Policy subsystem	(1) Basic attributes of the problem area (good), basic distribution of natural resources, fundamental sociocultural values and social structures, basic constitutional structures (2) Changes in socio-economic conditions, in public opinion, in systematic governing coalition, and policy decisions and impact (3) Coalition A (policy beliefs & resources), Policy Brokers, and Coalition B (policy beliefs & resources)
7	Shiffman and Smith's priority setting framework (2007)[65]	(1) Actor power (the strength of the individuals and networks concerned with the issue) (2) Ideas (the ways in which those involved with the issue understand and portray it) (3) Context (the environment in which actors operate) (4) Issue characteristics (features of the problem)	(1) Policy community cohesion, leadership, guiding institutions, civil society mobilization (2) Internal frame, external frame (3) Policy window, global governance structure. (4) Credible indicators, severity, effective interventions
8	Howlett et al. framework[55]	(1) Ideas & Institutions (2) Interests groups	(1) Lens for looking how policies are framed and presented (2) How changes in ideas or redefinition of issues affected interests groups

N°	Theoretical frameworks	Constructs	Variables
9	Kingdon's multiple-streams theory (1984)[58]	(1) Problem stream (2) Policy stream (3) Politics stream	(1) Indicators, focusing events, feedback (e.g. research, evaluations) (2) Visible participants, hidden participants (3) Policy 'entrepreneurs' or 'brokers' building coalitions
10	Punctuated equilibrium theory[67]	Policy image (the way in which a given problem and set of solutions are conceptualized Policy venue (the set of actors or institutions that make decisions concerning a particular set of issues)	Periods of 'stability' and incremental change with interruptions of crisis and more major changes
11	The 'top-down' multiple implantation theory (Dye, 2001)[68]	Public policy decision making process	(a) Policy implementation is seen to be what takes places after policy making is completed; (b) Policy is communicated hierarchically and usually belongs to policy makers at the 'top'
12	The 'bottom-up' multiple implantation theory (Lipsky, 1980)[69]	Public policy decision making process	(a) Shifts concern from the centre to the periphery; (b) highlights role of 'street level bureaucrats'

These frameworks and theories were used as the basis to create a single integrated study conceptual framework, which was then used for the empirical analysis of data generated from the study data. Development of the study conceptual framework is described in the next section.

2.6. Study conceptual framework

To better understand the dynamics of a multi-sectoral approach to health policy analysis from a political and organizational perspectives, this study argues that a more comprehensive conceptual framework than what currently exist is needed. A narrative synthesis review of the 8 frameworks and 4 theories identified in the literature and presented in Table 7 revealed that although each of them contributes to policy making, no single one provides a comprehensive overview of the multiplicity of factors involved in health policy analysis. For example, the Policy Triangle Framework (Walt & Gilson 1994)[53] with its four constructs of context, content, process and actors forms the basis for health policy analysis with regards to policy formulation. However, as accepted by Walt and Gilson themselves[44], the Policy Triangle Framework provides little variables and indicators needed to elucidate strategies of the policy process. Such variables include the interplay between ideas, institutions and interests, the equity lens and the patterns of interactions between the health sector and other sectors in changing policy. As a result of these limitations, an overarching framework termed the *Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis* (see Table 8) is proposed. This overarching framework is built around four major constructs of context, content, stakeholders, and strategies.

In the proposed framework, the *context* emphasizes the importance of the political, social and economic context as well as other factors that influence development and implementation of a multi-sectoral approach to health policy analysis. Political context entails political changes or critical events at the national and international level that have influenced policy development, such as health sector reforms, fiscal policies among others; or organizational changes, e.g., changes in government structure. The timing focuses on the timeline from the approval of a policy to the commencement of its implementation. Historical and social factors include historical origins of the policy and social factors such as an increase in the prevalence of non-communicable diseases. The economic context entails the country's economic growth as well as the global and local financial situation and conflicting development agendas. Lastly, the technological and international contexts include the influence of the information and communication technologies in the surveillance systems for notifiable conditions such as the

non-communicable disease as well as of the global agenda on sustainable developments[12] with its targets of reducing mortality from non-communicable disease and achieving universal health coverage and access to quality health services and medications.

The second construct, *content*, examines the rationale for developing the policy; the policy objectives; the type of interventions (upstream, midstream or downstream); the population level coverage of the interventions (universal or targeted); the implicit or explicit equity goals (improve the health of vulnerable groups, reduce health gaps between the most and least vulnerable groups, or flatten the social gradient in health across the entire population); and the mechanisms through which the policy is actualized.

The third construct, the policy *stakeholders*, assesses the roles of the key actors from government structures as well as other domestic and international institutions and interest groups that have a stake in the formulation and implementation of non-communicable disease prevention policies. The government structures include those at the central government level (executive, cabinet committees, governments ministries), the legislature (parliamentary committees) the judiciary and the sub-national politics.

The fourth construct, *strategies*, is linked to the first three because it assesses the way the stakeholders make intentional choices to maximise the benefits of a given policy in context and content. The choice of the word *strategies* instead of *process* was deliberated to clarify that each application of health policy involves stakeholders making intentional choices given the context and content of health policies to maximize the benefit they are seeking, not merely following static steps or processes.

To demonstrate its usefulness, the *Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis* was used to analyse tobacco control policies in Togo and in South Africa. This study was part of the Analysis of NCD Policies in Africa study, which assessed multi-sectoral approaches for formulating and implementing NCD prevention policies through case studies in six sub-Saharan African countries including South Africa, and Togo.[3] The multiple case study design employed an in-depth investigation of implementation of NCD prevention policy in real-life context.[72]

Table 8: Comprehensive Framework for the Multi-Sectoral Approach to Health Policy Analysis used to analyse tobacco control policies in Togo and in South Africa

N°	Categories	Variables	Indicators
1	C**ontext**	Political context	• Political changes or critical events at the national level that influence the development of tobacco control policy, • Health sector reforms, fiscal policies among others • organizational changes e.g. changes in government structure
		Timing, Historical/Social factors	• Timeline of policy development • Historical origins of the policy, including what issues it addressed, and how issue identification has evolved over time • Other global factors that have influenced the development of tobacco control policies and how they have influenced it (include global movements, declarations, and meetings). • Any social factors (e.g increase in prevalence of NCDs)
		Economic context	• Country economic growth • Global and local financial situation and conflicting development agendas
		Technological factors	• Technological factors that influence the development of Tobacco control policy
2	**Content**	Tobacco control policy interventions	• Specific policies developed in line with the best buy interventions included (e.g. tax increases, smoke-free indoor workplaces and public places, bans on tobacco advertising, promotion and sponsorship, health information and warnings, restricted access to retailed cigarettes) • Rationale for developing the policy • Type of interventions (upstream, midstream, or downstream) • Population level coverage of the interventions (universal or targeted) • Implicit or explicit equity goals of: o improve the health of vulnerable groups o reduce health gaps between most and least vulnerable groups, or o flatten the social gradient in health across the entire population

N°	Categories	Variables	Indicators
3	**Stakeholders**	Institutions (including rules, laws, norms and customs) and interests that led the process of developing tobacco control policies	• Government sector/department that led the process • Other sectors that were involved • Levels of government involved (national, local) • Existence of governance structures for multi-sectoral action at different levels (central government, parliament and civil service), their participation in and experiences with these structures. • Civil Society Organisations and private entities involved • Role of sectors involved in formulation (Funding meetings, provision of technical assistance)
		Formulation	• Extent of participation in policy formulation, • Experiences in policy formulation (what went well, and what could have been done differently) • Interests and concerns with the policy process, how these may have influenced their participation and how these were addressed. • Relevant institutions not involved in the formulation
		Implementation	• Key sectors/actors involved in the implementation, • Their role in the implementation • Relevant institutions not involved in implementation • Benefits of involving many actors in implementation • Challenges of involving many actors in implementation
4	**Strategies**	Formulation	• Extent to which the visions held by the health sector, by other sectors and by the ruling party are complementary, comprehensive and coherent • Means of engagement of other sectors, such as consultations, workshops, or meetings.

N°	Categories	Variables	Indicators
4	**Strategies**	Formulation	• Patterns of interaction between health and other sectors: o Information sharing, o Cooperation, o Coordination, or o Integration • Factors that contributed to successful engagement of other sectors • Benefits of involving different sectors in formulation process • Challenges encountered in the process
		Implementation	• Extent of implementation of the tobacco control best-buys and how implementation is proceeding in-country, • Government management styles: o Horizontal integration o Vertical integration o Mix of horizontal and vertical • Any gaps in implementation, the constraints and enabling factors to the implementation process, • Future plans for implementation of the best buys • Mechanisms for monitoring and evaluation
		Funding	• Funding available for implementation of each policy • Sources of funding • Amounts • Funding arrangements such as joint budgeting and delegated financing aimed at addressing tobacco control issues.
		Facilitating factors	• Factors facilitating working together of different sectors
		Hindering factors	• Factors that have hindered working together of different sectors
		Recommendations	• Recommendations and suggestions on how to make multi-sectorality better in future, • Mechanisms and structures through which multi-sectoral can be enhanced

CHAPTER 3 METHODS

This Chapter is structured into six parts, including study context, study design, data collection procedures, data management and analysis, ethical considerations, limitations of the study.

3.1. Study context

3.1.1 Study area

The research was conducted in South Africa, an upper-middle-income and Anglophone country and Togo, a low-income and Francophone one. Tobacco leaf is cultivated, processed, traded, and smoke tobacco products are manufactured in South Africa, whereas Togo mainly hosts tobacco products retailers. As shown in Figures 5 and 6 South Africa is in the southern part of the Africa, while Togo is in the western part between Burkina Faso in the North, Atlantic Ocean in the South, Benin in the East and Ghana in the West. The key profile features of the two countries are presented in Table 9 (Global Health Observatory).

Table 9: Profile of the South Africa and Togo

Profile features	South Africa	Togo
Geographical size (sq.km)	1 219 090	56 600
Total population (2016)	55 000 000[1]	7 606 000[2]
Gross national income per capita (GNI international $, 2016)[3]	13,196.8	1,490.5
Life expectancy at birth m/f (years, 2015)	59/66	59/61
Probability of dying between 15 and 60 years m/f (per 1 000 population, 2015)	386/272	309/266
Total expenditure on health per capita (Intl $, 2014)	1,148	76
Total expenditure on health as % of GDP (2014)	8.8	5.2
Percentage of population living in urban areas	62%	38.0%
Population proportion between ages 30 and 70 years	38%	28.2%
Income group	Upper middle	Low

[1] STATS SA : 2016 CS Results: http://cs2016.statssa.gov.za/ (accessed 6-August-2017).

[2] https://countryeconomy.com/demography/population/togo (accessed 6-August-2017).

3: GDP per capita in South Africa and Togo in 2016. https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD (accessed 27-February-2018).

Figure 5 shows the Map of South Africa
(Source: planet l. Map of South Africa. 2017. https://www.lonelyplanet.com/maps/africa/south-africa/; Accessed 6-August-2017).

Figure 6 shows the Map of Togo
(Source: planet l. Map of Togo. 2017. https://www.lonelyplanet.com/maps/africa/togo/; Accessed 6-August-2017).

3.1.2. Study population

The research drew from various sectors selected using a combination of purposive and "snowball" sampling from domestic and international institutions and other interest groups based on their expected role in tobacco control policy formulation and implementation.[73] .The study participants presented in Table 10 were key informants who either participated or should have participated in the NCD prevention policy process. These individuals included:

- Senior decision makers in the selected sectors such as department or division heads or program managers.
- Heads of NGOs or other actors involved in NCD prevention programs or projects.

- Heads of private sector institutions or departments and programs within those institutions involved in NCD prevention.

To ensure optimal variability across relevant sectors and institutions, the study planned to organise in-depth interviews with up to thirty key informants in each country through a purposive sampling whereby a tracer technique was used to select index key informants and a snowballing technique[73] to identify additional respondents during interviews with index key informants. Table 11 presents the matrix that was used to recruit key informants.

Agreements to participate in the study by identified potential key informants were sought through an initial telephone or email contact. Once they agreed to participate, the information sheet and an outline of the interview were sent to them in advance of the scheduled interview time. Lastly, the interviews were confirmed a few days and/or hours before it due date.

Table 10: Targeted domestic and international institutions and interest groups for key-informants' interviews

Institutions		Interest groups	
Domestic	**International**	**Domestic**	**International**
Executive (President and prime minister)	Intergovernmental organisations (WHO)	Civil society	British American Tobacco Philip Morris International Japan Tobacco International
The cabinet	Supranational government institutions (EU, ECOWAS, UEMOA, SADEC)	Research institutions	Union Against Tuberculosis and Lung Disease American Cancer Society, International Africa Tobacco Control Consortium
Government ministries (health, agriculture, education, law enforcement, transport, trade, finance, judiciary, communication, urban and industrial development etc..)	Individual government-sponsored donor organizations (DFID, IDRC, NORAD, AFD)	The media	
The legislature	Private foundations (Bill and Melinda Gates Foundation		
The judiciary			
Local government			

Table 11: Matrix for identifying key informants

N°	Sectors (institutions and interest groups)	Index key informant (tracer)	Other respondents (snowballing)
1	Health	a) X	a) X1 b) X2 c) X3 d) X4
2	Education	b) Y	a) Y1 b) Y2 c) Y3
3	Law enforcement	c) Z	a) Z1 b) Z2
4	Transport		
5	Finance		
6	Agriculture		
7	Trade		
8	Industry		
9	Communication/media		
10	Research institutions		
11	Civil society		
12	Tobacco industries		

3.2. Study design

This is a health policy and systems research approach on assessing the extent of use of MSA in the formulation and implementation of non-communicable disease prevention policies with a specific focus on tobacco control policies. The methodology is a case-study design described as an in-depth investigation of a phenomenon (in this case, multi-sectoral approach to formulation and implementation of tobacco control policies) in its real-life context.[72] Therefore, it is expected that a case of "MSA to implement tobacco control policies" should reflect a multi-sectoral approach towards healthy public policy-making involving national or provincial level of governments with institutions and interest groups collaborating to develop national policies, strategies or plans on tobacco control. These national policies, strategies or plans should contain public health interventions aimed at improving the health of a population by eliminating or

reducing their consumption of tobacco products and exposure to tobacco smoke. Tobacco control interventions include, but are not limited to, the ones related to the WHO NCDs "best buys" interventions, namely:

- Protecting people from tobacco smoke and banning smoking in public places.
- Warning about the dangers of tobacco use.
- Enforcing bans on tobacco advertising, promotion and sponsorship.
- Raising taxes on tobacco.

3.3. Data collection procedures

This was an independent study inspired by the one on the Analysis of NCDs Prevention Policies in Africa, which assessed multi-sectoral approaches to formulating and implementing NCDs prevention policies through case studies in five sub-Saharan African countries including.[3] The study data were collected through documentary reviews and in in-depth interviews with key informants.

3.3.1. Document reviews

Documentary reviews addressed available policies, strategies, plans and progress reports related to the formulating and implementing of NCDs prevention measures in South Africa and in Togo with a focus on policies addressing the major risk factors of NCDs. The key policy variables included in the review guide were content, context, process and actors.[74] The content refers to specific policies developed in line with the WHO recommended "best buys" interventions for NCDs prevention and control summarised in Table 4 in Chapter 2. The context includes the political, historical, social and economic contextual drivers of the NCDs prevention policy making process. Actors include an individual, group, organisation or group of organisations that act in the agenda-setting stage (initiator) or subsequent stages (actors)[75]

3.3.2. Interviews

The in-depth interviews focussed on tobacco control policies in South Africa and in Togo. A semi-structured interview guide was developed (Appendix 2) with open and closed ended questions focusing on the tobacco control policy context, policy content, actors involved in the process, and the implementation status. This guide was used to interview key informants who either participated or should have participated in the tobacco control policy process. In addition, data were collected on how an MSA was employed or not, the processes undertaken to ensure that it was followed, the challenges encountered, what worked and what did not work. The interviews were conducted at times and venues mutually agreed upon by the research team and respondents. The chosen venues for the interviews were in private places free from distractions and other security risks. Prior to the interview, the interviewers explained to the interviewees the purpose of the study, risks and benefit to participating, the right to withdraw at any time without penalty, and confidentiality. The key informants interviewed included domestic and international institutions and interest groups that were selected based on their expected role in formulating and implementing tobacco control policies. All interviews were conducted according to ethical guidelines and most were recorded using a digital recorder. The interviews lasted an average of 45-60 minutes.

3.3.3. Summary of data sources and techniques

Table 12 summarizes the links between the research questions, objectives, data collection techniques and tools.

Table 12: Research questions, objectives, data collection techniques and tools.

Research questions	Research objectives	Data collection sources or techniques	Data collection tools
What NCDs prevention policies exist in Togo and in South Africa?	To take stock of existing NCDs prevention policies related to the NCDs "best buys" interventions in South Africa and in Togo.	Policies, strategies, plans and progress reports on the formulation and implementation of NCDs prevention measures in South Africa and in Togo	Policy review guide
How are policies on NCDs prevention initiated and implemented in both countries?	To examine evidence of MSA in those policies using operational criteria for MSA in both countries.	Policies, strategies, plans and progress reports on the formulation and implementation of NCD prevention measures in South Africa and in Togo	Policy review guide
To what extent was MSA employed in the formulation and implementation of the tobacco control policies?	To assess the extent of the use of MSA in the formulation and implementation of the tobacco control policies in both countries	Policies, strategies, plans and progress reports on the formulation and implementation of tobacco control measures in South Africa and in Togo In-depth interview	Policy review guide Interview guide
What are the perceived enablers and barriers to the use of the MSA in the formulation and implementation of the tobacco control policies?	To assess factors, which may facilitate or hinder the use of MSA in the formulation and implementation of tobacco control policies in both countries	In-depth interview	Interview guide
What mechanisms can be employed in both countries for improving or reinforcing multi-sectorality to tobacco control?	To make recommendations on improving multi-sectoral approach in reducing tobacco consumption and exposure to tobacco smoke in both countries	In-depth interview	Interview guide

3.4. Data management and analysis

Qualitative data were mainly collected for this study. This section describes the data management, framework analysis and discusses the trustworthiness of the analysis.

3.4.1. Data management

Tape recorded qualitative data were transcribed, cleaned and saved in word format. Data cleansing consist in double checking the transcriptions of all the recorded interviews and organising work sessions with the interviewers to address inter-listener variabilities, which were minors. A filing system was set up for the following key components of the research: i) interview guides, ii) consent forms, iii) field notes, iv) transcripts, v) socio-demographic data sheet of study participants, vi) code book, and vii) list of study participants. All the research data were stored on a password-secured hard drive of the data entry computer. Copies of these data were backed up and saved on an external hard drive. The original plan as in the research protocol was to import to upload transcripts into the qualitative data management software Nvivo, but in the end Microsoft Excel 2010 software was used.

3.4.2. Data analysis procedures

Data analysis and interpretation were iterative. The study used a deductive content analysis approach, which is appropriate for policy-relevant qualitative data. This approach uses an analytical framework featuring key constructs and variables as initial coding categories.[76] Qualitative codes to categorize responses were pre-determined based on the *Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis*, built around four constructs of context, content, stakeholders and strategies. To make them suitable for empirical analysis, the constructs were operationalized in terms of variables with indicators as depicted in Table 8. The variables were used to code the transcripts. Consequently, the **content** of the available policies, strategies and plans that include population health interventions to eliminate or reduce consumption of tobacco products and exposure to tobacco smoke in South Africa and in Togo as of 31 December 2016 were examined. The examination included looking at the rationale, policy

objectives, type of interventions (upstream, midstream, or downstream); population level coverage of the interventions (universal or targeted); implicit or explicit equity goals (e.g. to improve the health of vulnerable groups, to reduce health gaps between the most and least vulnerable groups, or flatten the social gradient in health across the entire population); and mechanisms through which the policy is actualized. The **context** was also examined through various parameters, including historical, social, political, economic, technological or international or exogenous ones. Given the policy content and context, the espoused **strategies** helped assess the way **stakeholders** made intentional choices to maximise the required benefits when applying the policy at issue.

Nevertheless, the coding allowed for other emerging themes outside the framework used. Microsoft Excel 2010 software was used to organise data and perform thematic content analysis. The software was used to collate and consolidate the transcriptions and identify text linked with each content area and key themes. Relevant quotations were taken verbatim to illustrate views, concepts and support conclusions using the Giorgi's phenomenological approach, which focuses on the experiences of participants with shared life experiences.[77]

Descriptive statistics were used to report on available quantitative data on population level outcomes such as prevalence of current smokers, proportion of heavy drinkers, proportion of adults getting adequate physical activity, the proportion consuming adequate amounts of fruits and vegetables, the demand for hypertension treatment. There was therefore no need to use explanatory statistics such as Mantel Haenszel Chi-Square tests and multivariate regressions to compare differences in proportions and means considering contextual factors.

3.4.3. Credibility of the analysis

This is a qualitative study whose quality and rigor is appreciated by the trustworthiness of the analysis. Therefore, the quality of data collected and collated was assessed using the following criteria suggested by Robson in 2002[4]:

- Confirmability: Do findings and conclusions from case studies on tobacco control policies in Togo and in South Africa confirm the general findings or thinking about the effectiveness of the use of MSA in the formulation of NCDs prevention policies?
- Dependability: Was the research process logical and well documented?
- Credibility: Is there a match between participants' views and the researcher's reconstruction of them?
- Transferability: Do the findings generate insights that are transferable to other settings?
- The rigor[4] of the research methodological approach were assessed by:
    - The validity of the frameworks used
    - The extent of the application of principle of triangulation in data collection, collation and analysis
    - The documentation of the feedback of the study participants about the key findings of the study, and
    - The number and calibre of those who have accepted to peer review the findings of the study.

Overall, the quality assessment suggested that the data was robust and of sufficient quality to answer the study questions.

3.5. Ethical considerations

3.5.1. Ethical approval process

The study protocol was approved by the Health Sciences Faculty Ethics Committee on 25 November 2015 with reference number **552/2015** (Appendix 3). All study activities were reviewed and overseen by appropriate local ethical review boards in Togo (Ref:682/2014/MS/CAB/SG/DPLET/CBRS) and in South Africa (HSRC Ref: 2/19/02/114).

3.5.2. Ethical principles

Although the magnitude and probability of occurrence of adverse effects to the participants in the study were very low as it is not biomedical research, the study adhered to the following general research ethics principles:

1. Privacy: The interviews were conducted in places and environments that allowed respondents to freely express their views without fear of victimization;
2. Confidentiality: The identity of the key informants was protected and the findings will be presented showing the sectors they represent rather than their names or positions. Whenever possible two or more people were interviewed for each sector to avoid the possibility of someone automatically deducing who they are. Data collected through in-depth interviews were tape recorded whenever possible and later transcribed.
3. Voluntary participation: Participation in any aspect of the study was voluntary throughout the interview process. Participants were free to withdraw their consent to participate at any time during and after the interview. This was made clear in the consent form administered before every interview.
4. Benefit of research: There were no directs benefits to the study participants. The expected benefit will be downstream once the evidence generated is utilized to improve the policy making process and resulting health outcomes.
5. Sharing of research findings: A manuscript related to the study conceptual framework was submitted on 19 September 2017 to the International Journal of Health Services and

was accepted for publication on 29 January 2018 with reference number ID IJHS-17-0196.R2. Another manuscript related to the gist of the thesis is submitted in January

6. 2018 to BMC Public Health. It is also planned to share the key findings, conclusions and recommendations at international, regional and national scientific conferences and through other means (more accessible to non-academic audiences) such as such research briefs, fact sheets, media releases.
7. Measures to minimize risks: The risks to participants were minimal and all necessary safeguards considered during data collection. No participants were interviewed without informed consent. Prior to the data collection, selected participants read a written consent script that contained the following clarifications/explanations: why they were invited, purpose of the study, expected interview duration and study procedures, benefits of the study, research risks, participation cost and study staff and ethical review board contact details (for participants to refer with any pertinent questions about the research, or likewise table their complaints).

To ensure adherence to the above ethics principles, the surveyors were trained to acquire competences and attitudes needed to interview people regardless of race, social status, nationality, gender or level of education. In addition to being familiarized with key messages related to the study, the surveyors could phone to request assistance when facing ethical issues not anticipated in the research protocol.

3.6. Limitations

The study synthesized existing frameworks for public policy analysis into the Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis. From a theoretical perspective, the study could have missed relevant frameworks for public policy analysis by accessing only English and French language papers and by limiting the search to health policy (e.g., articles related to health interventions that are not policy-oriented could also have been useful). However, the identified frameworks and synthesized comprehensive framework of the study contain the most important elements of health policy analysis. Regarding key informant interviews, it was difficult to reach some policy makers due to their busy schedules particularly

in South Africa; moreover, most of the key informants did not have copies of the policies at hand and this made it difficult for them to substantiate their opinions during the interviews. As a result, most of the key-informants in both countries referred the interviewers to the index-informants from the health department, which is the sector that initiated and led the policy process in both countries. Nevertheless, some of the informants from the civil society organisations involved in policy implementation in South Africa shared electronic copies of the working documents such as strategies and reports. In the absence of data from field observation, the level of implementation of the identified policies was assessed mainly through triangulation of the opinions of the key informants with available date on progress reports.

CHAPTER 4 FINDINGS

We present the findings of this two-country case study by addressing the five research questions per case and then comparing the two cases. To address the first two questions, we used data generated from the documentary review and analysed them by referring to the WHO recommended "best buys" interventions for NCDs prevention and control and to the policy variables (content, context, process and actors) of the policy triangle framework[53] described in Chapter 2. The last three questions of the study were addressed with data generated both from the documentary review and in-depth interviews of key informants; these data were analysed with the constructs (content, context, stakeholders and strategies) and indicators of the study conceptual framework also described in Chapter 2. Therefore, this chapter is structured into three main sections, including findings from documentary review on NCDs prevention policies in South Africa and in Togo, findings from each country case study on tobacco control policies, and comparative analysis of the findings from both the documentary review and case studies in the two country settings.

4.1. Documentary Reviews

The purpose of the documentary reviews was to assess NCDs prevention policies addressing NCD risk factors- unhealthy diets, tobacco control, alcohol abuse and physical inactivity in South Africa and in Togo. We reviewed 97 documents in South Africa and 40 in Togo. The findings from the documentary review in both country settings are presented in this section from three standpoints: status of formulation and implementation of policies addressing the major NCD risk factors, contextual factors and roles of the actors, and evidence and extent of application of MSA in the NCD "best buys" interventions.

4.1.1. Findings from documentary reviews in South Africa

4.1.1.1. Status of formulation and implementation of policies addressing the major NCD risk factors in South Africa

Findings from documentary review in South Africa showed the government has developed policies related to the WHO recommended "best buys" interventions for NCDs prevention and control. These policies include legislations, government's white papers and national strategic and actions plans. As depicted in Table 13 more efforts were put on addressing tobacco and alcohol than on unhealthy diet and physical inactivity. The extent of implementation of these policies is summarised in Table 14, based on the 2014 WHO[8] report stating 10 progress indicators to monitor Member States' progress towards implementing their 2011 and 2014 commitments to develop national NCDs responses.

Table 13: Evidence and timelines of policies formulated to address major NCD risk factors in South Africa

Year	Risks Factors	Key policy events
1993	tobacco use	Tobacco Products Control Acts
1994	tobacco use	Tobacco Control Regulations
1999	Tobacco use	Tobacco Products Control Amendment Act
2000	Tobacco use	Tobacco Control Regulations-Amendments
2003	Harmful use of Alcohol	Liquor Act
2007	Tobacco use	Tobacco Products Amendment Act
2008	Tobacco use	Tobacco Products Regulations
2011	Tobacco use	Tobacco Products Control Regulations
	Unhealthy diet	Regulation relating to transfat in food stuffs Proposed alcohol adverting ban
2013	unhealthy diet	Regulations for reduction of salt content in Processed foods
2013	unhealthy diet	Food and Nutrition security policy

Table 14: Level of implementation of policies addressing the major risk factors of NCDs in South Africa.[8]

N[0]	Indicators	Level	Comments
1	National NCD targets and indicators	F	-
2	Mortality data	P	-
3	Risk factors surveys	P	-
4	National integrated NCDs policy/ strategy/action plan	N	-
5	Tobacco demand-reduction measures	P	Tax on tobacco products is 35 % of the retail price in Sa (far below the 70 % recommended by WHO)
6	Harmful use of alcohol reduction measures	P	-
7	Unhealthy diet reduction measures	P	-
8	Public awareness on reduction on diet and/or physical activity	P	-
9	Guidelines for the management of major NCDs	-	-
10	Drugs therapy/counselling for high risk persons	DK	-

F = fully achieved; **P** = partially achieved; **N** = not achieved; **DK** = don't know; - = documentation not available

4.1.1.2. Contextual factors and roles of the actors

Regarding the political, historical, social and economic context, findings from the documentary review show that the contextual drivers of NCDs prevention policies in South Africa were different in apartheid and post-apartheid era. Indeed, during the apartheid era, the political context was not in favour of measures addressing the risk factors of NCD, particularly those related to controlling tobacco use. However, the post-apartheid state has been pro-active in the prevention and control of NCDs because the governments of South Africa established the Directorate for Chronic Diseases, Disability and Geriatrics unit within the Department of Health in 1996 and is signatory of at least three global commitments related to the NCDs, which are the 2011 United Nations Political Declaration on NCDs, the 2014 United Nations Outcome Document on NCDs and the 2030 agenda for sustainable development with the goal of reducing by one third premature mortality from NCDs. Since then, a range of national policies, strategies and plans on prevention and control of NCDs have been formulated, and of the 54 NCDs related national policies, strategies and plans found, only three were developed prior to 1996.

Data from the documentary reviews permitted to summarise the list and roles of key actors involved in the formulation and implementation of policies addressing major risks factors of NCDs in South Africa presented in Table 15. It can be inferred from Table 15 that: (1) most of the expected stakeholders were involved in the formulation and implementation of policies addressing NCDs in South Africa; (2) more involvement was noticed for stakeholders from institutions and interest groups of the civil society organisations; (3) the National Department of Health initiated and led the policy making process while other institutions and interest groups supported it; and (4) the private sector opposed the process.

Table 15: List and roles of key actors involved in the formulation and implementation of policies addressing major risk factors of NCD in South Africa.

Sectors	Institutions	Roles
Health departments	• National Department of Health (NDH) • Provincial departments of health • District Department of Health • City Department of Health • NDH: Tshwane district, Western Cape Government; Ekurhuleni Health District; • City of Tshwane	NDH initiated and led the process of policy formulation
Other departments of the Government	• Department of Arts and Culture; • Department of Trade and Industry; • Departments of Sports and Recreation; • Department of Basic Education; • Department of Social Development • South Africa Council for Medical Aid Schemes;	Supported policy
Civil Society Organisations (CSOs)	• Heart and Stroke Foundation South Africa • National Kidney Foundation South Africa • Diabetes South Africa • South African Depression and Anxiety Group • South African National Council on Alcoholism and Drug Dependence • CANSA: The Cancer Association of South Africa • PHANGO: Patient Health Alliance Non-Governmental Organisations • Campaigning or Cancer • Soul City • Alcoholics Anonymous • National Council Against Smoking • CRL Commission • DENOSA: Democratic Nursing Organisation of South Africa; • South African Medical Association • Traditional Healers Organisation; • Kedibone Health Systems Consultant	Supported policy formulation; identified gaps

Sectors	Institutions	Roles
Research Institutions	• North West University • University of Cape Town • University of Witwatersrand • Tshwane University of Technology • Medical Research Council	Supported policy formulation with scientific evidence
Private Sector	• Nestle; • South African Chamber of Mines; • UFF Agri Asset Management	Opposed the policy

4.1.1.3. Evidence and extent of application of MSA in the NCD "best buys" in South Africa

The operational definitions of sector and MSA for the purpose of the study are the following:

- Sector is defined as "a distinct subset of a market, society, industry or economy where components share similar characteristics".
- Evidence of MSA is involvement of any two or more sectors, one of which must be government

In order to assess the extent of MSA in NCD prevention policy formulation and implementation, the study identified key sectors that had involvement in at least one risk factor (tobacco use, harmful alcohol use, unhealthy diet, physical inactivity) for at least one participating country. These sectors include: Health, Education, Judiciary, Law enforcement, Trade, Transport, Finance, Agriculture, the Media, Research institutions and Civil society organizations.

Involvement was defined as either (1) document review or (2) a participant specified inclusion of an organization or individual in proceedings, deliberations, testimony, policy drafting, policy implementation, or any other aspect directly related to policy formulation or implementation. Given the retrospective document review and reliance on participants' memories, the study were unable to clarify across all sectors and related institutions and interest groups the extent to which each was actively involved (e.g., attending a single meeting vs. actively drafting document vs. providing testimony).

Sector involvement includes any institutions or interest groups involved in "best-buys" NCDs prevention policy making; for instance: (1) public sector/government (ministry/cabinet level organization); (2) civil society (NGO, community based organization, faith based organizations); (3) private sector (pharmaceutical company, other industry) and (4) research/academic institution (university); (5) international organizations/bilateral or multilateral

In this study, sectoral involvement was categorised as low for just two, as medium when greater than two and below or equal to four, and as high, when greater than 4. Table 16 depicts the extent of MSA in policies addressing major NCDs risk factors in South Africa based on the number of sectors involved.

Table 16: Extent of MSA by "best-buys" NCD prevention policies in SA

Best-buys policies	Number of involved	MSA Score
Tobacco	* Government: Health * Civil Society Organizations (CSO): Heart and Stroke Foundation South Africa, the Cancer Association of South Africa, PHANGO, National Council Against Smoking, Democratic Nursing Organization of South Africa, South African Medical Association * Research Institutions University of Cape Town, Medical Research Council, University of Witwatersrand, University of Pretoria	High (10)
Alcohol	* Government: Social development * CSO: PHANGO, South African National Council on Alcoholism and Drug Dependence, Alcoholics Anonymous	Medium (4)
Nutrition and diet	* Government: Health * CSO: PHANGO, Diabetes South Africa	Medium (3)
Physical activity	* Government: Sport and Recreation * CSO: Soul City	Low

4.1.2. Findings from documentary reviews in Togo

4.1.2.1. Status of formulation and implementation of policies addressing the major NCD risk factors in Togo

Findings from the policies addressing the major NCDs risk factors in Togo and summarised in Table 17 showed that the government developed only some of the policies related to the WHO recommended "best buy" interventions for NCDs prevention and control. The extent of implementation of these policies is summarised in Table 18, based the 2014 WHO[8] report on the agreed-upon 10 progress indicators to monitor Member States' progress towards implementing their 2011 and 2014 commitments to develop national NCD responses.

Table 17: Evidence and timelines of policies formulated to address major NCD risk factors in Togo

Year	Risk Factors	Key Policy events
2009	Tobacco use, harmful use of alcohol	Public Health law
2010	Tobacco use, harmful use of alcohol	Taxes on tobacco and alcohol
2010	Tobacco use	Tobacco Control Law
2012	Tobacco use	Tobacco Control Regulations
2012	All the risk factors	Integrated national policy and strategic plan for NCDs prevention and Control (2012-2015)
2012	unhealthy diet	National strategic plan for Nutrition (2012-2015)

Table 18: Level of implementation of policies addressing major risk factors of NCDs in Togo

N[0]	Indicators	Togo	Comments
1	National NCD targets and indicators	F	-
2	Mortality data	N	-
3	Risk factors surveys	P	* 2010 STEPS surveys in Togo and 2007 South African Attitude Survey
4	National integrated NCD policy/ strategies/action plan	F**	** It is a four-year (2012-2015) integrated national policy and strategic plan for NCD prevention and control
5	Tobacco demand-reduction measures	P	Tax on tobacco products is 45 % [3] of the Retail price in Togo (far below the 70 % recommended by WHO)
6	Harmful use of alcohol reduction measures	P	-
7	Unhealthy diet reduction measures	N	-
8	Public awareness on diet/ physical activity	F	-
9	Guidelines for the management of major NCDs	P*	* adaptation and implementation at small scale of the WHO Package of Essential Non-communicable Disease Intervention for Primary Health Care in Low-Resource Settings.
10	Drug therapy/counselling for high risk persons	N	-

F = fully achieved; **P** = partially achieved; **N** = not achieved; **DK** = don't know; - = documentation not available

[3] It is the maximum of the 15 to 45% range recommended by the Economic and Monetary Union of West African States, and it is in the 15 to 100% range recommended by the Economic Community of West African States (ECOWAS)

In Togo, though the 2012-2015 national policy and strategic plan for NCDs integrates several NCDs, the Health Department decided to strengthen national capacity to integrate and scale-up interventions for detection, prevention, treatment and care of cardiovascular diseases (heart disease, stroke, hypertension) and diabetes and their risk factors in primary health care settings. Thus, the National NCDs Prevention and Control Program adapted the WHO Package of Essential Non-communicable Disease Intervention for Primary Health Care in Low-Resource Settings to national priorities.[3] These standards have been implemented at a small scale in three urban health districts with the support of the WHO. From 1990 to 2010, the National NCDs Prevention and Control Program was a small unit within the Epidemiology Program of the Health Department; it became a stand-alone NCDs Control Programme in 2011 with the appointment of a national coordinator. Lastly, the government of Togo allocated XOF 50 million (USD100,000) for activities in the 2015 country budget.

[3] WHO PEN : *www.who.int/nmh/publications/essential_ncd_interventions_lr_settings.pdf*

4.1.2.2. Contextual factors and roles of the actors

Regarding the political, historical, social and economic context, findings from the documentary review show that the contextual drivers of NCDs prevention policies in Togo were different before and after 2010. Indeed, from 1990 to 2010, NCDs was a small unit within the Epidemiology Program of the Department of Health; it became a stand-alone NCDs Control Programme in 2011 following the 2010 STEPS survey. Since then, the government of Togo is signatory of at least 3 global commitments related to NCDs, which are the 2011 United Nations Political Declaration on NCDs, the 2014 United Nations Outcome Document on NCDs and the 2030 agenda for sustainable development with the goal of reducing by one third premature mortality from NCDs. To realise these commitments, the Government adopted the prevention and control of NCDs as one of the five priorities of the 2012-2015 national health strategic plan, established the national NCDs program within the Ministry of Health in November 2011, and developed a four-year (2012-2015) integrated national policy and strategic plan for NCDs.

Data from the documentary reviews permitted to summarise the list and roles of key actors involved in the formulation and implementation of policies addressing major risks factors of NCDs in Togo presented in Table 19. Data from Table 19 show: (1) most of the expected stakeholders were involved in the formulation and implementation of policies addressing NCDs in Togo; (2) more involvement was noticed for stakeholders from the institutions and interest groups of the government; (3) the National Department of Health initiated and led the policy making process while other institutions and interest groups supported it; and (4) the private sector opposed the process.

Table 19: List and roles of key actors involved in the formulation and implementation of policies addressing NCD in Togo

Sectors	Institutions	Roles
Health departments	• National Programme Against Smoking • Teaching Hospital Sylvanus Olympio • WHO Country Office • Teaching Hospital Campus	National Programme initiated and led the process of policy formulation
Other departments of the Government	• Department Education • Department of Justice • Departments of Trade and Transport • Department of Finance/Treasury • Department of Agriculture • Department of Communication	Supported policy
Civil Society Organisations	• National Alliance of Consumers and Environment • National Association of Consumers • National League of Consumers	Supported policy formulation; identified gaps
Private Sector	• Tobacco Retailers	Opposed the policy

4.1.2.3. Evidence and extent of application of MSA in the NCD "best buys" in Togo

As in South Africa, sectoral involvement in Togo was also categorised as low when just two sectors were involved, medium when two to four sectors, and as high when greater than four sectors were involved. Table 20 depicts the extent of MSA in policies addressing major NCD risk factors in Togo based on the number of sectors involved.

Table 20: Extent of MSA by "best-buys" NCD prevention policies in Togo

Best-buys policies	Involved sectors (numbers)	MSA Score
Tobacco	• Government: Health, Transport, and Communication (3) • CSO: National Alliance of Consumers and Environment, National Association of Consumers (2)	High (5)
Alcohol	• Government: Trade (1) • CSO: National Association of Consumers (1)	Low (2)
Physical activity	• Government: Youth and Sport and Communication (2)	Low (2)
Nutrition and Diet		None

Overall, the review of NCDs prevention policies addressing major risk factors showed evidence of use of MSA in formulating and implementing NCDs prevention policies in both countries. However, out of the four major risk factors of NCDs assessed, substantial efforts were made mainly on tobacco control policies in both countries. Therefore, a deeper investigation on tobacco control policies through country case studies was warranted. The following sections present the two country case studies.

4.2. Case studies

Country case studies permitted further investigation of the tobacco control policy making process in SA and Togo. With data generated both from the documentary review and in-depth interviews of key informants, and analysed with the constructs (content, context, stakeholders and strategies) and variables of the study conceptual framework, the case studies permitted to address the last three questions of the study. Before presenting the findings from each case, this section starts with the completeness of the study.

4.2.1. Completeness of the key informant interviews

Out of the 60 planned (30 in each country) interviews, 56 key informants were interviewed.

In South Africa, researchers interviewed 26 key informants to assess the roles of stakeholders in tobacco control policy-making. These purposefully selected key policy actors drawn from government departments as well as other domestic and international institutions and interest groups that have a stake in formulating and implementing tobacco control policies in South Africa. Fourteen (54%) of the 26 key informants were male and twelve (46%) were female. In terms of duty stations 9 (35%) were working in Johannesburg, 13 (50%) in Pretoria, 2 (8%) in Cape Town, 1 (4%) in Germiston, and 1 (4%) in Tzaneen.

In Togo, researchers interviewed 30 key informants. Key policy actors were intentionally selected from government structures as well as other interest groups, and domestic or international institutions that were stakeholders in tobacco policies formulation and implementation in Togo. Twenty-five (83%) of the 30 key informants were male and five (17%) were female. In terms of duty stations, all were working in Lomé, the capital city.

In both countries, more socio-demographic data of the key informants are not presented because they were not provided or could violate confidentiality.

Table 21 depicts the distribution of the key informants interviewed based on the matrix presented in table 11. The conduct, record and transcribe of the interviews were contracted. The semi-structured interview tool used (Appendix 2) permitted probing and in-depth exploration of issues based on the study conceptual framework.

The interviews were conducted in English in South Africa and in French in Togo. The transcripts of Togo's interviews were translated into English before being merged with the ones of South Africa. The merged transcripts were coded and organised. The content analysis and interpretation were made based on the key themes of the study conceptual framework. Appendix 1 presents a summary of the transcripts with a focus on sectors of affiliation, location, date of, and quotes extracted from, the interviews.

Table 21: Distribution of key informants by affiliation and settings

N^0	Institutions and Interest Groups	Togo		South Africa	
		Index Key Informant (tracer)	Other Respondents (snowballing)	Index Key Informant (Tracer)	Other Respondents (Snowballing)
1	Health	1	3	1	3
2	Education	1	1	1	1
3	Judiciary	1	1	1	1
4	Legislature	0	1	0	0
5	law Enforcement	1	5	1	1
6	Trade and transport	2	0	1	0
7	Finance/Treasure	1	2	1	0
8	Agriculture	1	0	1	0
9	The Media	1	2	1	1
10	Research Institutions	0	0	1	0
11	SCO (Civil Society Organizations)	1	3	2	8
12	Tobacco Retailers	1	1	0	0
Sub-total		**11**	**19**	**12**	**14**
Grand Total		**30**		**26**	

A reasonable spread of actors across public, civil society and private sectors were interviewed for the study. The non-government actors, namely the civil society organisations and the private sector (in this case tobacco retailer) provided valuable insights into experiences with MSA in policy development processes. Although the study had more government actors, the distribution of respondents covered the critical three sectors of the state, namely the public sector (government), the private sector and the civil society sector that are expected to be involved in the formulation and implementation of NCD prevention policies.

4.2.2. Findings from Case study in South Africa

This section presents the findings of a deductive content analysis of the data collected from key informants in South Africa. This presentation follows the four constructs of the study conceptual framework, namely content, context, stakeholders and strategies.

4.2.2.1. Content of the tobacco control policies in South Africa

4.2.2.1.1. Description of the policy content

In SA, the first Tobacco Products Control Act passed in June 17, 1993 mainly aimed to mandate health warnings for cigarette packs or on any advertising material and to prohibit smoking in public transport.[78] This Act did not meet international standards on several measures because of weak political will due to close ties between the tobacco industry and the ruling apartheid National Party. A window of opportunity for a major policy change was opened from 1994 because of the end of apartheid following the first democratic elections organised in South Africa, won by the African National Congress.

The second Tobacco Act passed in April 1999 was more extensive because it:

- Introduced a ban on all tobacco advertising and sponsorships;
- Restricted smoking in enclosed public places;
- Restricted “point-of-sale” advertising to price and availability only,
- Gave the Minister of Health the power to prescribe maximum yields of tar and other constituents.
- Banned free distribution and rewards, and
- Restricted further the use of vending machines.

The third piece of legislation on tobacco is the multifaceted tobacco control Amendment Act No. 23 passed in September 2007. It includes the following provisions:

(1) No person may smoke any tobacco product in:(i) a public place; (ii) any area within a prescribed distance from a window of, ventilation inlet of, doorway to or entrance into a public place; (iii) any motor vehicle when a child under the age of 12 years is present in that vehicle;

and (iv) in any prescribed outdoor public place where persons are likely to congregate within close proximity of one another or where smoking may pose a fire or other hazard.

(2) No person shall manufacture a tobacco product unless it complies with such standards as may be prescribed. The standards that a tobacco product must comply with include: (i) the amounts of substances that may be contained in the product or its emissions; (ii) substances that may or may not be added to the product; (iii) the ignition propensity of cigarettes; and (iv) product design and composition.

(3) A manufacturer of a tobacco product must submit to the Minister of Health and to the public information in respect of: (i) research conducted into a tobacco product by a manufacturer or by a person who conducted research paid for in whole or in part by a tobacco manufacturer; (ii) the quantity of a tobacco product manufactured; (iii) marketing expenditure; and (iv) information on product composition, ingredients, hazardous properties and emissions

(4) The penalty for restaurants, pubs, bars and workplaces that allow smoking is increased from R200 to R50,000 (maximum). The fine for an individual who smokes in a public place will be a maximum of R500.

The last piece of legislation is the Act 63 of 2008 which came into force on 21 August 2009. It permitted the regulation of the following activities:

- Direct or indirect advertising of a tobacco product, and the practice of paying film and television producers to show tobacco products on screen (so-called product placement) are prohibited;
- Warning messages, with pictures showing the consequences of tobacco use, must appear on tobacco packages;
- “Charitable” donations can be made by tobacco companies provided they are not used for purposes of advertising;
- “False” or “misleading” health claims on tobacco packages are barred – the use of labels like “light,” “mild” or “low-tar” which falsely imply that such cigarettes are less harmful than regular cigarettes are banned;
- The free distribution of cigarettes and the use of coupons and gifts to promote tobacco sales and use is prohibited;
- Self-service displays of tobacco products at retail are banned;

- The display of tobacco products at wholesale and retail is regulated;
- The sale of tobacco by and to those under the age of 18 is banned;
- Mail order and internet sales are forbidden; and
- Vending machines may only be in places to which those under the age of 18 do not have access.

4.2.2.1.2. Analysis of the policy content

This section presents the findings from an analysis of the tobacco control policies in SA from three standpoints: the timeline, the "best buy" interventions covered, and level of implementation of those best buys.

With regards to the timeline, Table 22 summarises the purpose and time-gaps from adoption to the proclamation of commencement of the tobacco Acts in South Africa.

Table 22: Timeline of tobacco control policies development in SA

Policies/Acts	Purpose	Approval	Assent	Gazette	Commencement
83 of 1993: Tobacco Products Controls Act, 1993	To prohibit or restrict smoking in public places; to regulate the sale and advertising of tobacco products in certain respects and to prescribe what is to be reflected on packages; and to provide for matters connected therewith.	17 June 1993	23 June 1993	December 1994	1 February 1995
12 of 1999: Tobacco Products Control Amendment Act,1999	To amend the Tobacco Products Control Act, 1993, so as to amend and insert certain definitions; to provide for the prohibition of advertising and promotion of tobacco products; to provide further, for the prohibition of advertising and promotion of tobacco products in relation to sponsored events; to prohibit the free distribution of tobacco products and the receipt of gifts or cash prizes in contests, lotteries or games to or by the purchaser of a tobacco product in consideration of such purchase; to provide for the prescription of maximum yields of tar, nicotine and other constituents in tobacco products; to increase fines; and to provide for matters connected therewith.	March 1999	14 April 1999	23 April 1999	1 October 2000

Policies/ Acts	Purpose	Approval	Assent	Gazette	Commencement
23 of 2007: Tobacco Products Control Amendment Act, 2007	To amend the Tobacco Products Control Act, 1993, so as to define certain expressions and to amend certain definitions; to provide anew for the control over the smoking of tobacco products; to make provision for standards in respect of the manufacturing and export of tobacco products; to extend the Minister's power to make regulations; and to increase penalties; and to provide for matters connected therewith.	September 2007	23 February 2008	28 February 2008	21 August 2009
63 of 2008: Tobacco Products Control Amendment Act, 2008	To amend the Tobacco Products Control Act, 1993, so as to define certain expressions and to amend certain definitions; to provide anew for the advertising, sponsorship, promotion, distribution and information required in respect of the packaging and labelling of tobacco products; to make the standards that apply to manufacturers of tobacco products applicable to importers of tobacco products; to prohibit the sale of tobacco products to and by persons under the age of 18 years; to extend the provisions in respect of free distribution of tobacco products; to provide anew for tobacco sales by means of vending machines; to extend the Minister's power to make regulations; and to adjust the provisions in respect of offences and penalties; and to provide for matters connected therewith.	August 2008	5 January 2009	9 January 2009	21 August 2009

Referring to the WHO recommended "best buys" interventions for NCDs prevention and control presented in Table 4, the findings from the case study on tobacco control policies in South Africa are summarised in Table 23.

Table 23: WHO recommended "best buy" interventions included in the tobacco control policies in South Africa

Name of policy	Tax increases on Tobacco	Smoke-free indoor work places and public places	Health information and warnings about tobacco	Bans on advertising and promo-tion
Tobacco Products Control, Act 1993	YES	NO	YES	YES
Tobacco Products Control Amendment Act 1999	YES	NO	YES	YES
Tobacco Products Control Amendment Act, 2007	YES	YES	YES	YES
Tobacco Products Control Amendment Act, 2008	YES	YES	YES	YES

Findings from the tobacco control policies formulated in South Africa and summarised in Table 23 showed that through four incremental pieces of legislation between 1993 and 2009, the South Africa government passed comprehensive national tobacco control policies that were not fully WHO FCTC compliant because the smoke free law allows for designated smoking areas instead of imposing a comprehensive ban on smoking in all public places as recommended in the WHO FCTC. Those policies aim to improve the health of vulnerable groups, to reduce health gaps between the most and least vulnerable groups, and to flatten the social gradient in health across the entire population. Table 24 summarises the extent of implementation of tobacco control policies in South Africa. Out of the four "best buy" interventions, the tax increases on tobacco was the most difficult one to adopt and implement. Interviewees supported the challenges of taxation efforts. For example, an academic official indicated that taxation was a significant challenge, including keeping tax increases consistent with inflation. A health department official

indicated the challenges of the health department leading the implementation of tobacco taxes when the department does not have specific taxation expertise.

Table 24: Extent of implementation of the "best buys" interventions included in the tobacco control policies in SA

"Best buy" interventions (2014-2016)	Interventions implemented	Answers
Tax increases on tobacco	The tax applies to all tobacco products (cigarettes, snuffs, chewing tobacco) (some products = partial)	Yes
	The tax level during the study	35%
Smoke-free indoor work places and public places	There is a national smoke free policy that covers all public places (some cities or settings = partial)	Yes
	There are enforced penalties for non-compliance (having penalties but not enforced = partial)	Partial
Health information and warnings about tobacco	Multiple warnings/images are rotated from time to time, applies to all brands/products	Yes
	Large, clear, visible (at least 30% coverage) and legible all brands/all products (if only some of these words are in the legislation = partial)	Yes
	Health warning includes pictures or pictograms all brands/all products	Yes
	Include constituents and emissions of tobacco (e.g., how much tar) on all brands/products	Yes
	In official country language on all brands (only some brands/products = partial)	Yes
	Required on all tobacco products (if on only some products or brands, partial)	Yes
Bans on advertising and promotion	Ban advertising, promotion and sponsorship of all tobacco products	Yes
	Ban for all forms of mass media	Yes
	Disclosure of expenditure on advertising by industry	Yes

4.2.2.2. Political, historical, social and economic context

Regarding the political, historical, social and economic context, findings from the documentary review and key informants' interviews show that the contextual drivers of tobacco control policies in South Africa were different in apartheid and post-apartheid eras. During the apartheid era, the political context did not favour measures in controlling tobacco use for two main reasons: first, South Africa is home to many tobacco leaf producers and manufacturing companies that do not support restrictions on tobacco production; second, the tobacco industry was dominated by white, Afrikaans-speaking South Africans with close ties to the apartheid government. The historical and social contexts began to turn in favour of public health measures for controlling tobacco use in South Africa in 1988 when a special issue on tobacco was published in the *South African Medical Journal* to coincide with the first World No Tobacco Day. The issue addressed the health effects of tobacco, the economic effect of tobacco, and advocated the need for tobacco policy in South Africa. The collapse of apartheid in the early 1990s and the new African National Congress-led government provided a window of opportunity from the political stream for the tobacco control policy-making process. In addition, an academic key stakeholder (S24) noted on 2016/07/16 that a 1993 international conference on tobacco use and its control in Africa held in Harare, Zimbabwe was attended by scientist and Minister of Health Dr Nkosazana Dlamini-Zuma who gave the opening speech in her capacity as a representative of the ANC; the stakeholder noted her presence and speech sent a strong message to the conference participants including a large South African delegation and people from about 35 other countries, that the African National Congress was "sensitized" to promote tobacco control policies in South Africa. The change in political landscape continued with the first democratic elections in 1994, which brought into power Nelson Mandela, enormously helped tobacco control cause in South Africa. Indeed, the African National Congress, the new ruling party, had no alliance with the tobacco industry and had much stronger commitment to an effective tobacco control policy since Nelson Mandela had consistently voiced his strong support for anti-smoking legislation and was on record as having called for a "world free of tobacco."[78]

The consistent political support since 1994 enabled hectic, but successful development and implementation of the tobacco control policies as described above. A key stakeholder at a civil society organization also mentioned Dr. Dlamini-Zuma as being a specific powerful voice who supported tobacco control policies despite pressure from the tobacco industry in South Africa and Afrikaans speaking whites, who protected the tobacco industry, to maintain the status quo. Likewise, Dr. Dlamini-Zuma was also on record for requiring smoke-free cabinet meetings.[78] The stakeholder mentioned above indicated that the ability of the health office to use data to identify impacts was particularly useful (e.g., countering tobacco companies' warnings about the policies resulting in job loss by showing minimal impact on jobs).

4.2.2.3. Stakeholders

To assess the roles of stakeholders in tobacco control policy-making, 26 key informants were interviewed in South Africa. These purposefully selected key policy actors drawn from government departments as well as other domestic and international institutions and interest groups that have a stake in the formulation and implementation of tobacco control policies in SA. This section presents the levels of involvements and roles of the stakeholders interviewed.

4.2.2.3.1. Overview of the key informants

Table 25 depicts the key informants and the policy process stages they were involved in, in South Africa.

Table 25: Stakeholder involvement in the Policy Process by Sector in South Africa

	Key Informants	Policy Process involvement	
Institutions and Interest groups	**Location**	**Formulation**	**Implementation**
Health	National Department of Health	YES	YES
	Department of Health,	NO	YES
	Mpumalanga District Department of Health, Ekurhuleni District	NO	YES
	Health Promotion Unit	YES	YES
Education	Department of Basic Education	NO	YES
	Department of Higher Education	NO	YES
Judiciary	Judge/Justice	NO	YES
	Attorney	NO	YES
Law enforcement	Metro Police	NO	YES
	South Africa Polices Services	NO	YES
Trade and Transport	Department of transport	NO	YES
Finance/Treasury	Department of Treasury	NO	YES
Agriculture	Rural Development Institute	NO	
The Media	Tswane TV	NO	YES
	Pretoria News	NO	YES
Research Institutions	Sefako Makgatho Health Sciences University	YES	YES
Civil Society Organizations	SANCO: South African National Civic Organization	YES	YES
	NCD Alliance	YES	YES
	DENOSA: Democratic Nursing Organization of South Africa Campaigning for cancer	NO	YES
	CANSA: The Cancer Association of South Africa	YES	YES
	HSF: Heart and Stroke Foundation	YES	YES
	NCAS: National Council Against Smoking	YES	YES
	Pharmaceutical Company Association	NO	YES
	Tobacco Institute	NO	YES
	SANCA: South Africa National Council on Alcoholism And drug dependence	NO	YES

4.2.2.3.2. Roles of the stakeholders in policy formulation and implementation

Integrating data from both documentary reviews and key-informants' interviews allowed us to describe the stakeholders' role description from four standpoints: lead sector, range of sectors involved, policy stage of involvement, and actual roles in each stage. Table 25 provides an overview of stakeholders involved in the tobacco control policy-making process; several observations are noteworthy. Stakeholders from institutions and interest groups of the civil society organisations tended to be more involved than those from other sectors such as law, transportation, and education. The government sector, through the Department of Health, initiated and led the process, and the civil society organisations and research institutions supported it. All stakeholders acknowledged the important role of research institutions and civil society organisations in policy formulation and implementation, even though these organizations were not always involved in both stages. Some stakeholders not involved in policy implementation but who were asked to be involved in implementation, such as those from justice, law enforcement and media said they felt it would have been helpful and more collaborative if they had been involved in the formulation process as well. For example, a police official said (S16) on 2016/05/25, "*It's a pity we were not involved*" and both police and justice officials suggested that their involvement could have strengthened the policies by clarifying policies for monitoring and penalties for those to do not follow the implementation guidelines. Similarly, a media official (S26) suggested on 2016/05/20 the media industry could have also offered more in the formulation process instead of being involved "*mostly in complying with these policies by abiding to rules and regulations on how not to publicize tobacco products through our platforms*."

4.2.2.4. Strategies employed by the stakeholders

Strategies, the fourth major construct of the study conceptual framework, convey the dynamic and iterative intentional choices of the stakeholders to maximise the required benefit in a given policy context and content. Results indicated the government, through the Department of Health, employed strategies of leading the process, engaging other institutions and interest groups through consultations, workshops and meetings. The non-governmental organizations typically provided scientific evidence at these engagements. These consultations, workshops, and meetings were focused on information sharing and rarely expanded to cooperation, coordination or integration. The post-apartheid government, with the support of the health department, research institutions and civil society organisations employed specific strategies of science, evidence and strong activism to overcome resistance from tobacco industries and others opposed to the changes. The government did not allocate funding for these strategies, which were mostly funded from bilateral and multilateral donors and other partners.

4.2.2.5. Evidence and extent of the use of MSA

Table 25 outlines the stakeholders who participated in South Africa's tobacco policy formulation and implementation. These data indicate that the MSA was employed to a great extent in that many stakeholders (more than four) were involved in formulating and implementing tobacco control policies. As noted, more stakeholders were involved in the implementation than in the formulation stage, and civil society organisations were highly involved.

4.2.2.6. Facilitating and hindering factors of the use of MSA in tobacco control policies in South Africa

In addition to understanding stakeholder engagements in policy formulation and implementation, the study specifically sought to identify the factors that might have facilitated or hindered the use of MSA in the policy process. The following section presents the findings from SA.

Table 26 summarises the facilitators and barriers to the MSA in the formulation and implementation stages of tobacco control policies in South Africa. The most important facilitating factors stakeholders described are (1) local expertise through several scientific publications from research and academic institutions and (2) strong political will from the post-apartheid government. Primary barriers include the tobacco industry's influence given its financial revenue to the government and its ties with the ruling power, particularly during the apartheid era.

Table 26: Facilitators and barriers to the MSA in tobacco control policies in South Africa, in decreasing order of importance

Policy stages	Facilitators	Barriers
Formulation	• Evidence on the burden of the NCD risk factors • Local expertise: evidence from research that supports legislation • Political will: public participation requirement in policy formulation • Nucleus group –to initiate and drive the policy formulation process- critical in ensuring that content and process issues are covered in policy drafting • A central co-ordination point - workshops and drafting sessions strategically convened to include most stakeholders • Ratification of the WHO FCTC in April 2005 • Personal motivation of the stakeholders: champions and advocates • Donor catalytic funding	• The tobacco industry • Weakness in coordination: patterns of interaction between health and other sectors limited to information sharing • Differences in stakeholders expectations/interests • Inadequate funding and overdependence on donors • Lack of participation of women groups

Policy stages	Facilitators	Barriers
Implementation	• Local expertise • Political will • Personal motivation of the stakeholders • Ratification of the WHO FCTC in April 2005	• The tobacco industry • Government management styles: more vertical than horizontal integration • Public participation: MSA is a requirement in policy-making but not in policy implementation. Nothing compels stakeholders to collaborate in implementing the tobacco control policy and other NCD policies in general • Differences in stakeholders expectations/interests • Inadequate funding and overdependence on donors • Lack of participation of women groups

4.2.3. Findings from Case study in Togo

This section presents the findings of a deductive content analysis of the data collected from key informants in Togo. This presentation follows the four constructs of the study conceptual framework, namely content, context, stakeholders and strategies.

4.2.3.1. Content of the tobacco control policies in Togo

4.2.3.1.1. Description of the policy content

The development of tobacco control policies and legislation in Togo dates to its 2009 public health law under its articles 89 to 93 related to the fight against social scourges, including harmful use alcohol use, tobacco use, substance abuse and prostitution. This law, however, focused largely on restraining (not banning) advertising on tobacco use (Article 90), warning about the dangers (Article 91) and banning smoking in public places (Article 92). The law did not say anything about raising taxes on tobacco and it was not really enforced. Significant efforts at controlling tobacco use started with the ratification of the WHO FCTC on
on November 15, 2005 . Indeed, practicing the WHO FCTC, the Togolese Government adopted and implemented comprehensive legislative, executive and administrative measures. The key legislative measure is the enactment of the law N°2010-017 of December 31, 2010 related to manufacturing, trade and consumption of cigarette and other tobacco- products. To implement this law, the Government signed five cabinet decrees (executive measures) and 4 ministerial orders (administrative measures). These are described as follows.

The cabinet decrees are:

- Protecting people from tobacco smoke and banning smoking in public places: decree N°2012-046/PR of July 11, 2012;
- Warning about the dangers of tobacco use: decree N°2012-047/PR of July 11, 2012;
- Roles and responsibilities of the National Committee against Tobacco Consumption: decree N°2012-050/PR of July 11, 2012;
- Restricting access to retailed tobacco: decree N°2012-071/PR of September 12, 2012;

- Enforcing bans on tobacco advertising, promotion and sponsorship: decree N°2012-072/PR of September 12, 2012.

The ministerial orders are:

- The list and rotation of health-related advertisements to put on the retailed unit of cigarette and other tobacco-contained products: order N°136/2013/MS/CAB/DGS/DSSP of August 20, 2013;
- The printing characteristics of health-related advertisements in terms of font, policies and frame: order N°137/2013/MS/CAB/DGS/DSSP of August 20, 2013;
- How to set up a smoking corner in public settings where smoking is forbidden: order N°138/2013/MS/CAB/DGS/DSSP of August 20, 2013;
- Samples of how to label smoking ban as well as the smoking corner in public places: order N°139/2013/MS/CAB/DGS/DSSP of August 20, 2013.

4.2.3.1.2. Analysis of the policy content

The tobacco control policies in Togo were also analysed from three standpoints; the timeline, the "best buy" interventions covered, and level of implementation of those "best buys". With regards to the timeline, Table 27 summarises the time-gap from the passing and promulgation of the law to its implementation through executive and administrative measures in Togo.

Table 27: Time-gap of development and implementation of tobacco control policies in Togo

Policies	Purpose	Adoption	Promulgation	Commencement
Law N°2010-017 of 2010 related to manufacturing, trade and consumption of cigarette and other tobacco-contained products.	To define appropriate measures to protect current and upcoming generations from devastating health, social, environmental and economic effects of consumption of cigarette and other tobacco-contained products as well as exposition to tobacco smoke.	31 December 2010	31 December 2010	1 January 2011
Executive measures: cabinet decrees	- N°2012-046/PR of July 2012: protecting people from tobacco smoke and banning smoking in public places;			11July 2012
	- N°2012-047/PR of July 2012: application of norms related to packaging and labelling of tobacco products;			11July 2012
	- N°2012-050/PR of July 2012: composition, responsibilities and operation of the National Committee Against Tobacco Consumption;			11July 2012
	- N°2012-071/PR of September 2012: regulating access to retailed tobacco products;			12 September 2012
	- N°2012-072/PR of September 2012: bans on tobacco advertising, promotion and sponsorship;			12 September 2012

Policies	Purpose	Adoption	Promulgation	Commencement
Administrative measures: ministerial orders	- N°136/2013/MS/CAB/DGS/DSSP of August 2013: the list and rotation of health-related advertisements to put on the retailed unit of cigarette and other tobacco-contained products;			20August 2013*
	- N°137/2013/MS/CAB/DGS/DSSP of August 2013: the printing characteristics of health-related advertisements in terms of font, policies and frame;			20August 2013*
	- N°138/2013/MS/CAB/DGS/DSSP of August 2013: how to set up a smoking corner in public settings where smoking is forbidden;			20August 2013
	- N°139/2013/MS/CAB/DGS/DSSP of August 2013: samples of how to label smoking ban as well as the smoking corner in public places;			20August 2013

Notes:*the implementation of the ministerial orders N°136 and 137 related to the health advertisements on the retailed unit actually started on September 1, 2014: pictorial warnings in French and in local languages that cover more than half of the front and back of cigarette packs.

Referring to the WHO recommended “best buys” interventions for NCD prevention and control presented in Table 4, the findings from the case study on tobacco control policies in Togo are summarised in Table 28.

Table 28: WHO recommended "best buys" interventions included in the tobacco control policies in Togo.

Name of policy	Tax increases on tobacco	Smoke-free indoor work places and public places	Health information and warnings about tobacco	Bans on advertising and promotion
Law N°2010-017 of 2010 on manufacturing, trade and consumption of cigarette and other tobacco-contained products.	YES	YES	No	YES
CD* N°2012-046/PR of July 2012: Protecting people from tobacco smoke and banning smoking in public places;		YES		
CD* N°2012-047/PR of July 2012: warning about the dangers of tobacco use;			YES	
CD* N°2012-071/PR of September 2012: restricting access to retailed tobacco;				YES
CD* N°2012-072/PR of September 2012: enforcing bans on tobacco advertising, promotion and sponsorship;				YES

***CD** = Cabinet Decrees

Findings from the tobacco control policies formulated in Togo and summarised in Table 28 demonstrate that the policies adopted in Togo through the law and its related regulations are not fully compliant with the fully WHO FCTC because the health warnings were removed from the version of the law approved by the parliament. Those policies aim to improve the health of vulnerable groups, to reduce health gaps between the most and least vulnerable groups, and to flatten the social gradient in health across the entire population. The extent of implementation of tobacco control policies in Togo is summarised in Table 29.

Of the four "best buy" interventions, stakeholders indicated the tax increases on tobacco was the most difficult one to adopt and implement, specifically because of tobacco industry influence against the tax increases. A Treasury Department official provided an example that when the department sent information to the tobacco industry about proposed tax increases, the tobacco industry responded by providing reports that tobacco control tends to increase illicit trade and that Togo was especially vulnerable because of its porous borders. The Treasury official (T9) said on 2016/05/30, "*That was [the industry's] way of dissuading us from following what the Department of Health is saying*." A law enforcement stakeholder (T30) emphasized on 2016/06/08 that, despite challenges from the tobacco industry, stakeholders together were still taking a big picture view to prevent problems related to tobacco: *"We want to avoid [tobacco] products being dumped in the country."* Similarly, a community service organization stakeholder (T24) described on 2016/05/02 that the tobacco industry's "*interferences*" were able to delay implementation of the law requiring health warning pictures on tobacco products for a year.

Table 29: Extent of implementation of the "best buys" interventions included in the tobacco control policies in Togo

Best buys interventions (2014-2016)	Interventions implemented	Answer
Tax increases on tobacco	The tax applies to all tobacco products (cigarettes, snuffs, chewing tobacco) (some products = partial)	Yes
	The tax level during the study	45%
Smoke-free indoor work places and public places	There is a national smoke free policy that covers all public places (some cities or settings = partial)	Yes
	There are enforced penalties for non-compliance (having penalties but not enforced = partial)	Partial
Health information and warnings about tobacco	Multiple warnings/images are rotated from time to time, applies to all brands/products	No
	Large, clear, visible (at least 30% coverage) and legible all brands/all products (if only some of these words are in the legislation = partial)	Yes
	Health warning includes pictures or pictograms all brands/all products	Yes
	Include constituents and emissions of tobacco (e.g., how much tar) on all brands/products	Yes
	In official country language on all brands (only some brands/products = partial)	Yes
	Required on all tobacco products (if on only some products or brands, partial)	Yes
Bans on advertising and promotion	Ban advertising, promotion and sponsorship of all tobacco products	Yes
	Ban for all forms of mass media	Yes
	Disclosure of expenditure on advertising by industry	Yes

4.2.3.2. Political, historical, social and economic context

Regarding the political, historical, social and economic context, findings from the documentary review and key informant's interviews show that ratification of the WHO FCTC on November 15, 2005 by the country was the main contextual driver of tobacco control policies. A community service organization stakeholder (T24) said on 2016/05/02, *"It is mainly the commitment from WHO through its representative in Togo that helped get support for the development of some plans … [and the] FCTC obligation to report progress every two years precludes countries to stay behind and every country is willing to share with the world what it is doing."* Compared to South Africa, in Togo it was relatively easy for policy makers to achieve convergence about the nature of the problem, policy, and politics streams and to persuade the government to act. A law enforcement stakeholder (T30) articulated on 2016/06/08 the approach from his perspective: "*Togo has ratified a number of conventions and to abide by these conventions, there was a need to align national laws and regulations with the global commitments*." He went on to discuss the challenge of illicit use of Togo's ports by other countries to evade taxes and provide tobacco on the black market. Increasing awareness of this challenge led to a ministerial order to prohibit the practice.

4.2.3.3. Stakeholders

To assess the roles of stakeholders in tobacco control policy-making, 30 key informants were interviewed in Togo. Key policy actors were intentionally selected from government structures as well as other interest groups, and domestic or international institutions having stakes in tobacco policies formulation and implementation in Togo. This section presents the levels of involvement and roles of stakeholders interviewed.

4.2.3.3.1. Overview of the key informants

Table 30 depicts the key informants and their respective stages of involvement in the policy process, in Togo.

Table 30: Stakeholder involvement in the Policy Process by Sector in Togo.

Stakeholders		Policy Process involvement	
Institutions and interest groups	***Location***	***Formulation***	***Implementation***
Health	National Programme Against Smoking	YES	YES
	Teaching Hospital Sylvanus Olympio	NO	NO
	WHO Office	YES	YES
	Teaching Hospital Campus	NO	NO
Education	Department of Vocational Training	YES	YES
	Department of Vocational Training	NO	YES
Judiciary	Department of Justice	NO	YES
	Department of Justice	NO	YES
Legislature	Member of the Parliament	YES	NO
Law enforcement	National Council Against Drug	NO	YES
	Office of the Repression of illicit trade and money laundering	NO	YES
	Airport Control Police	NO	YES
	Airport Control Customs	NO	YES
	National Police Services Headquarters	NO	YES
	Judiciary police		
Trade & Transport	Department of Transport	YES	NO
	Department of Trade	NO	YES

Stakeholders		Policy Process involvement	
Institutions and interest groups	***Location***	***Formulation***	***Implementation***
Finance/Treasury	National Revenue Office	NO	YES
	National Revenue Office	NO	YES
	National Council for the Control of Public Bids	NO	YES
Agriculture	Department of Agriculture	NO	NO
The media	Department of Communication	YES	YES
	Department of Communication	YES	YES
	Private Radio Station	NO	YES
Civil Society Organisations	National Alliance of Consumers and Environment	YES	YES
	National Association of Consumers	YES	NO
	National League of Consumers	NO	NO
Tobacco industries	Tobacco Retailer	YES	YES
	Tobacco Retailer	YES	YES
	Consulting firm on Evaluation	NO	NO

4.2.3.3.2. Roles of the stakeholders in policy formulation and implementation

Integrating data from the documentary reviews and key informants' interviews enable us to describe the stakeholders' role from four standpoints: lead sector, range of sectors involved, stage of involvement, and actual roles in each stage. Data from Table 5 suggest that in Togo most of the expected stakeholders were involved in the tobacco control policy making process, with more involvement of stakeholders from government institutions. As in South Africa, Togo's government sector, through the Department of Health, initiated and led the process and was supported by the civil society organisations. Also similar to South Africa, representatives from justice, law enforcement and media who considered themselves as key stakeholders from the government sector felt left out of the policy formulation process, but were later called to act in policy implementation. A justice official (T12) said on 2016/05/04, "*I was not involved in the formulation of the law passed. I do not know[…] if the Justice [department] had shared their viewpoints about the infractions mentioned in the law. Thus, I think it is during the implementation of this law that the justice is approached just to implement the law.*" Similarly, a law enforcement (T26) official said on 2016/05/*06*, "*It is after the law was passed that the national anti-drug committee were approached to see how the law enforcement can contribute to its implementation. […] If I were involved in the formulation of the law I would have included some of the aspects of the fight against tobacco in the fight against drugs. I would have also shared my experience on the fight against drugs*."

4.2.3.4. Strategies employed by stakeholders

Strategies, the fourth major construct of the study conceptual framework, convey the dynamic and iterative intentional choices of the stakeholders to maximise the required benefit in a given policy context and content. Results indicate that, as in South Africa, the government, through the Department of Health, employed strategies of leading the process and engaging other institutions and interest groups through consultations, workshops and meetings. A health department stakeholder (T21) described on 2016/04/26 the department's role as a "*peacemaker*." He said, *"It is us who triggered the process and we produced, within a team with legal experts of the*

Department of Health, a draft which we shared with other departments of the government to check if the content of the draft is agreeable to them;…the Department of Health is the one that coordinates, monitors and evaluates. The other departments check the applicability in their domains." The non-governmental organizations typically provided scientific evidence at these engagements. These consultations, workshops, and meetings were focused on information sharing and rarely expanded to cooperation, coordination or integration. The government addressed resistance from the tobacco industry through the support of the WHO and the National Alliance of Consumers and Environment in the Department of Health. Finally, similar to South Africa, Togo's government did not allocate funding for these strategies, which were mostly funded from bilateral and multilateral donors and other partners.

4.2.3.5. Evidence and extent of the use of MSA

Table 30 outlines the stakeholders who participated in Togo's tobacco control policy formulation and implementation. As with South Africa, in Togo, MSA was employed to a great extent in that many stakeholders (more than four) were involved in formulating and implementing tobacco control policies. As noted, more stakeholders were involved at the implementation than at the formulation stage and civil society organisations were highly involved.

4.2.3.6. Facilitating and hindering factors of the use of MSA in tobacco control policies in Togo

In addition to understanding stakeholder engagements in policy formulation and implementation, the study specifically sought to identify factors facilitating or hindering the use of MSA in the policy process. The following section presents the findings in Togo. Table 31 summarises the facilitators and barriers to the MSA in the formulation and implementation stages of tobacco control policies. Data from Table 31 suggest that in Togo: (1) the WHO FCTC is the leading facilitator of the MSA in policy making process for tobacco control; and (2) stakeholders report the tobacco industry is the main barrier to formulating and implementing tobacco control policies. A health official stakeholder (T21) described on 2016/04/26 his view, "*The problem is that the tobacco industry did not want any policy on tobacco control and tried their best to block*

the law. But the Togo's authorities chose the health of the population and the law was passed; it is the tobacco industry that corrupts and precludes people from fulfilling their mission." An education official stakeholder (T17) provided on 2016/07/01 this strong perspective on the conflicting issues, "*In Togo, foreigners smoke a lot; however, we need them for country development. And more, there is democracy, freedom of movement of people and goods which make difficult to control the use of tobacco in the countries, not only in Togo. Now there is pressure from the tobacco industry. They are powerful people, clever, very strong who easily manage to corrupt.*" Compared to South Africa, there is less conflict in Togo about the role of the tobacco industry.

Table 31: Facilitators and barriers to the use of MSA in tobacco control policies in Togo, in decreasing order of importance

Policy stages	Facilitators	Barriers
Formulation	• Evidence on the burden of the NCD risk factors • Ratification of the WHO FCTC in November 2005 • Political will • Availability of local expertise • Donor catalytic funding • Personal motivation of the stakeholders	• Weakness in coordination: patterns of interaction between health and other sectors limited to information sharing • The tobacco industry • Differences in stakeholders expectations/interests • Inadequate funding and overdependence on donors • Lack of participation of women groups
Implementation	• Ratification of the WHO FCTC in November 2005 • Political will • Local expertise • donor catalytic funding • Personal motivation of the stakeholders	• The tobacco industry • Government management styles: more vertical than horizontal integration • Differences in stakeholders expectations/interests • Inadequate funding and overdependence on donors • Lack of participation of women groups

4.4. Comparative analysis of South Africa and Togo policy formulation and implementation

This section compares the findings from documentary reviews on NCD prevention policies addressing the four major risk factors and from the two case studies on tobacco control policies.

4.4.1. Documentary reviews

The study findings, presented in Tables 13, 16, 17 and 20 shows that in both countries:

(1) The policies addressing the major risk factors of NCDs namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity have been formulated and implemented, with all four 4 risk factors addressed in SA and only 3 in Togo, where unhealthy diet is yet to be addressed;

(2) There was evidence of use of MSA in policy making process although more in formulation than implementation;

(3) The number of stakeholders involved was high (more than 4) in tobacco control policies and low (just 2) in physical activity policies; on Alcohol, they were medium (3-4) in South Africa and low in Togo; and they were medium on Nutrition and Diet in South Africa.

4.4.2. Case studies

This section compares the findings of a deductive content analysis of data collected from key informants interviewed for an in-depth investigation of the multi-sectoral approach to formulating and implementing tobacco control policies in South Africa and Togo. The comparison follows the four constructs of the study conceptual framework, namely content, context, stakeholders and strategies.

4.4.2.1. Tobacco control policy content

Regarding policy content, a comparative analysis of the findings from both countries reveals that South Africa and Togo have passed comprehensive national legislations on tobacco control, which are not fully compliant with the WHO Framework Convention on Tobacco Control[14] they both ratified in 2005: in South Africa the smoke free law allows for designated smoking areas instead of imposing a comprehensive ban on smoking in all public places as recommended in the WHO FCTC, whereas in Togo the health warnings were removed from the version of the law approved by the parliament.Togo passed one bill for tobacco control in 2010, whereas South Africa required four incremental pieces of legislation between 1993 and 2009. Both countries issued many regulations to put these laws into practice. The WHO recommended "best buy" interventions included in the tobacco control policies in both countries are presented in Tables 23 and 28; the extent of implementation of these interventions are presented in Tables 24 and 29. In South Africa, there were time-gaps between approval of an act, its assent by the president and the publication in the government gazette and proclamation of commencement, whereas in Togo all these four actions were taken almost concomitantly. In both countries, tax increases on tobacco was the most difficult "best buy" interventions to adopt and implement.

4.4.2.2. Political, historical, social and economic context

Regarding the political, historical, social and economic context, findings from this study reveal that the contextual factors in both countries were dissimilar. South Africa is an upper middle-income country with tobacco leaf producers, firms and tobacco manufacturing companies, while Togo is a low-income country, hosting only some tobacco retailers. In South Africa, prior to 1993, the political, historical and social contexts of the tobacco control policy were characterised by a lack of government interest because the tobacco industry was dominated by white, Afrikaans-speaking South Africans with close ties to the apartheid government. In Togo, unlike in South Africa, tobacco control was not an issue of "high politics," so it was relatively easy to merge the problem, policy and politics streams and convince the government to act.

4.4.2.3. Stakeholders

Considering stakeholders (study findings presented in Tables 25 and 30), actors from the critical three sectors of the state, namely public sector (government), private sector and civil society[79] were involved in policy making on tobacco control in both countries. The government, through the Department of Health, led the process in both countries and had supports from civil society organisations to overcome barriers from the private sector. However, involvement and support of stakeholders from the research institutions and civil society organisations were more diverse, proactive and dynamic in South Africa than in Togo. Indeed, although the health department led the process in both countries, the research institutions and civil society organisations played a much greater role in South Africa than Togo. In both countries, the justice, law enforcement and media sectors who considered themselves as key stakeholders felt left out in the policy formulation process, especially when they were later called to act in policy implementation. Other sectors mainly involved in the implementation also stated that they should have been involved at the formulation stage.

4.4.2.4. Strategies

The study found the strategies employed in tobacco control policy making more straightforward in Togo than in South Africa. Indeed, in a low political context, with readily available evidence provided mainly by the WHO to the Health Department, policy makers in Togo managed to overcome resistance from the representatives of the tobacco and hospitality industry and persuade the Parliament to pass a tobacco control law almost compliant with the WHO FCTC[14]: health warning pictures were left out of the law in Togo. Conversely, the high political context in South Africa with stakeholders who have vested interests in blocking or weakening the tobacco control policies, the policy makers—led by the Department of Health and supported by the research institutions and the civil society organisations—used a combination of science, evidence and politics, including strong activism to succeed. Otherwise, in both countries, the health department led the process and engaged other sectors through consultations, workshops or meetings, mostly funded by the partners particularly in Togo. Furthermore, in both countries the

interaction between the health department and other sectors during policy formulation and implementation consisted mainly on information sharing and rarely went further to cooperation, coordination or integration. Lastly, in both countries no funding was earmarked or internally designated to implement tobacco control measures and most of the catalytic funds came from donors.

4.4.2.5. Evidence and extent of the use of MSA

The findings from the study presented in Tables 16 and 20 show that in both countries: (1) the case studies confirmed the evidence and the high level of the use of MSA for health in tobacco control policy formulation and implementation, (2) many stakeholders (more than 4) were involved in the formulation and implementation of tobacco control policies, (3) many of them were involved more at the implementation than at the formulation stage; and (4) civil society organisations were highly involved although more in South Africa than in Togo.

4.4.2.6. Facilitating and hindering factors of the MSA in tobacco control policies in South Africa and in Togo

Tables 26 and 31 display that the facilitators and barriers to the MSA were similar in nature, but were not of equal importance in both countries. Indeed, in South Africa, local expertise through several scientific publications from research and academic institutions and a strong political will initially from the post-apartheid government are the most important facilitating factors both at the policy formulation and implementation stages, and they are higher than the ratification of the WHO FCTC. Conversely, in Togo, the WHO FCTC is the leading facilitator of the MSA in tobacco control policy making process. In both countries, the tobacco industries have been the main barriers to formulating and implementing tobacco control policies, but they are stronger in South Africa than in Togo because of their noticeable contribution to country revenues and their ties to the ruling power, particularly during the apartheid era.

CHAPTER 5 DISCUSSION OF FINDINGS

The aim of this study was to determine the extent to which MSA has been used in the formulation and implementation of policies on NCDs "best buys" interventions particularly on tobacco use. To achieve this aim, we formulated the following 5 objectives: (1) to assess existing NCDs prevention policies related to the NCDs "best buys" interventions in Togo and in South Africa; (2) to examine evidence of MSA in those policies using operational criteria for MSA in both countries; (3) to assess the extent of the use of MSA in formulating and implementing tobacco control policies in both countries; (4) to assess factors, facilitating or hindering the use of MSA in formulating and implementing tobacco control policies in both countries; and (5) to make recommendations on improving MSA in reducing tobacco consumption and exposure to tobacco smoke in both countries. The key steps towards achieving these objectives consisted of: (1) reviewing existing policies, strategies, plans and progress reports on the formulation and implementation of NCDs prevention measures in South Africa and in Togo with a focus on policies addressing the major risk factors of NCDs; (2) developing a study conceptual framework; (3) investigating the use of MSA in the formulation and implementation of tobacco control policies through in-depth key-informant interviews in both countries; and (4) applying the study conceptual framework to analyse and report the findings from the documentary reviews and the case studies. Therefore, the purpose of this section is to discuss the findings of the study from four standpoints: (1) soundness of the formulation and level of implementation of tobacco control policies in South Africa and in Togo, (2) appropriateness of the study conceptual framework, (3) effectiveness of the use of MSA; and (4) extent of its understanding and use in these countries.

5.1. Soundness of the formulation and level implementation of tobacco control policies in South Africa and in Togo.

Results of the data analyses from documentary reviews and key-informant interviews show evidence of formulation and implementation in South Africa and in Togo of policies related to the WHO recommended "best buy" interventions to address tobacco use as a major NCDs risk factor. The formulation of such tobacco control policies in both countries was driven locally by the political, historical, social and economic contexts, and globally by the adoption of the WHO Framework Convention Tobacco Control. The stakeholders involved were more diverse, proactive and dynamic in South Africa than in Togo whereas the strategies employed were more straightforward in Togo than South Africa. The findings indicated that the process was led, in both countries, by the Department of Health instead of the cabinet or a supra-departmental commission, which did not permit significant interactions among other departments of the government (whole of government) that have a stake in tobacco control policy making. In the absence of such a whole of government approach[80], information sharing was identified as the main outcomes of the interaction between institutions and interest groups within and across three critical sectors of the state, namely public sector (government), private sector and civil society. This insufficient level of interactions contributed to the low implementation of tobacco control policies in both countries.

Case studies on tobacco control were also assessed in Cameroon, Kenya, Malawi and Nigeria between 2014 and 2016. Though data from those studies were analysed with the Policy Triangle Framework, some of their findings are similar to those of this study in the sense that different countries are at varying stages on the continuum of tobacco control policy formulation and implementation.[3] Indeed, South Africa, Kenya, Togo and Nigeria have fully developed policies signed into law whereas Cameroon has several piecemeal policies not yet signed into law and Malawi has not even ratified the WHO FCTC.

5.2. Appropriateness of the study conceptual framework

The World Health Organisation[1] postulated that to be effective, non-communicable disease prevention policies should focus on the four major modifiable risk factors of the four major diseases, be formulated and implemented through a multi-sectoral action for health, and be analysed from a political and organisational perspective of health policy analysis. Although scholars have proposed many conceptual frameworks to help understand the process of health policy making, their constructs are not holistic enough to analyse complex policies that require multi-sectoral approach to formulation and implementation such as those related to non-communicable disease prevention. This study synthesized the constructs of theories and frameworks identified in the literature to create a Comprehensive Framework for Multi-Sectoral Approach to Health Policy Analysis, which was then applied to a Case study of the analysis of tobacco control policy in Togo and in South Africa. This proposed comprehensive framework is built around four major constructs of context, content, stakeholders, and strategies. As a result of using it to analyse data collected from case studies of tobacco control policies in Togo and in South Africa, this study concludes that: (1) the framework adequately assesses the major components of the complex and multifaceted aspects of health policy formulation and implementation; and (2) allows researchers and policy makers to think of health beyond the health department and to acknowledge that actions on health-related outcomes, determinants of health or health equity could be more effective when taken by sectors outside the health sectors. This proposed conceptual framework promises to be a more comprehensive analytical tool by addressing some of the limitations of the existing frameworks such as the interplay between ideas, institutions and interests, which were not explicit in the Policy Triangle Framework as pointed out by Howlett.[55] It also helps to address equity as well as interaction between health care and other sectors, which are key policy variable well elaborated in the Health in All Policies framework.[56] Further, the study framework considered Kingdon's Three-Stream Theory in the context construct.[58]

5.3. Effectiveness of the use of MSA in tobacco control policies in South Africa and in Togo

Table 32 presents the distribution of sectors' involvement in policy formulation and implementation in South Africa and in Togo.

Table 32: Distribution of sectors' involvement in tobacco control policy formulation and implementation in South Africa and in Togo.

South Africa				Togo			
Sectors	Organisa-tions*	Formu-lation**	Implemen-tation**	Sectors	Organisations*	Formulation**	Implementation**
Health	4	2	4	Health	4	2	2
Education	2	0	2	Education	2	1	2
Judiciary	2	0	2	Judiciary	2	0	2
Legislature	NA	NA	NA	Legislature	1	1	0
Law enforcement	2	0	2	Law enforcement	6	0	6
Trade & transport	1	0	1	Trade & transport	2	1	1
Finance/treasury	1	0	1	Finance/treasury	3	0	3
Agriculture	1	0	0	Agriculture	1	0	0
The media	2	0	2	The media	3	2	3
Research Institutions	1	1	1	Research Institutions	NA	NA	NA
Civil society organisation	10	6	10	Civil society organisation	3	2	1
Tobacco industry	NA	NA	NA		3	2	2
Total	26			Total	30		

*number of representatives of organisations (institutions or interest groups) interviewed within sectors

**number of organisations within sectors involved in policy formulation or implementation

The operational definition of evidence of MSA in this study is "involvement of any two or more sectors, one of which must be government". Data depicted in table 32 indicate that, in both countries, the MSA was employed to a great extent in that many sectors (more than four) were

involved in formulating and implementing tobacco control policies. In both countries more sectors were involved in the implementation than in the formulation stage, and civil society organisations were highly involved particularly in South Africa.

However, the study findings indicate variety in the extent to which sectors were at least nominally involved in policy formulation and implementation, and participants generally stated that MSA was very useful in understanding stakeholder perspectives and formulating actionable plans that address multiple contingencies. Further, since the findings are limited in a retrospective study design, it was not possible to assess the extent to which each participated (e.g., attending a single meeting vs. actively drafting document). It would be useful for the measurement of MSA to provide a baseline for what "counts" as involvement. Therefore, the study recommends that merely attending a meeting is not likely enough to contribute meaningfully to policy formulation and that some sort of "active" participation should be measured (e.g., providing testimony, information, drafting, or review).

The coding scheme for low, medium, and high MSA provided an overview of the variety of MSA in formulating and implementing tobacco control policies in South Africa and in Togo, but the study was not able to assess the relationship between the number of sectors involved and the country's effectiveness and timeliness in policy formulation. The study findings did not also enable to comment on the impact of single versus multiple stakeholders within one sector; for example, the health sector is considered to be participating if only the health ministry is involved, but the health sector could have greater impact if sector participation includes the health ministry, non-governmental organizations related to health, and health researchers compared to health ministry participation only. It would be useful to establish a measurement tool that can be used across types of policy formulation that accurately assesses (a) the extent to which stakeholders were "actively" participating in policy formulation, (b) the impact of multiple organizations within sector compared to a single organization within a sector, and (c) the number or kind of sectors (e.g., as many as possible, specific key sectors, a minimum number of sector) that are most highly associated with effective and timely policy formulation and implementation. This two-country study was not able to address all of these challenges, but it does provide a solid first step in baseline information about MSA and in clarifying measurement issues that can be addressed by future research.

In addition to assessing and thereby confirming the effectiveness of the use of MSA in tobacco control policies in South Africa and Togo, this study weighted the extent of its understanding and use, which is discussed in the next section.

5.4. Extent of the understanding and use of MSA in tobacco control policies in South Africa and in Togo.

The concept of four by four refers to the fact that the four major NCDs namely cardiovascular diseases, cancers, chronic respiratory diseases and diabetes share four major behavioural risk factors, which are tobacco use, unhealthy diet, physical inactivity and harmful alcohol use. As the first focus of global response to the challenge of NCDs, the 2011 United Nations High Level Meeting Political Declaration "recognizes that the rising prevalence, morbidity and mortality of NCDs worldwide can be largely prevented and controlled through collective and multi-sectoral action by all member states and other relevant stakeholders…" The WHO 2013-2020 Action Plan for the Prevention and Control of NCDs reiterated the MSA as cornerstone for NCDs prevention at the population level. This plan also emphasised some "best buys" interventions for NCDs prevention including measures to reduce the four common risk factors of tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. Moreover, these attempts would deliver the greatest benefit in reducing population level risks in a cost-effective manner.[81] The WHO (1998) has defined the Inter-Sectoral Action for Health approach as "a recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone."[31] In the above mentioned United Nations documents, the terms multi-sectoral and inter-sectoral are used interchangeably and it is within this context that WHO Member States, including South Africa and Togo signed and started the implementation of the global commitments related to NCDs prevention and control.

In reference to the three policy strategies proposed by Kickbusch[34] to synthetize the various interpretations and scope of the multi-sectoral approach in the context of health described in Chapter 2.4, the extent of understanding and use of the MSA in formulating and implementing

tobacco control policies in South Africa and in Togo can be characterized as an Inter-Sectoral Action for Health. Indeed, because, in both countries, the process was led by the Department of Health instead of the Cabinet or a Supra-departmental commission, it did not permit significant interactions among other government departments (whole of government) that have a stake in tobacco control policy making. Further, on the one hand, Inter-Sectoral Action for Health is a narrow and issue-centred approach to the MSA which aims to integrate a specific health concern into other relevant sectors' policies, strategies and plan, in line with the 1998 WHO definition mentioned above. On the other hand, it is at the beginning of a continuum of degrees of policy integration[82] based on Kickbusch's MSA typology. Therefore, the Inter-Sectoral Action for Health understanding and use of the multi-sectoral approach to tobacco control policies in South Africa and in Togo can be further characterized as minimal.

CHAPTER 6 CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions from the findings of the study

This section presents the summary of the key findings from both the documentary reviews and case studies, and draws conclusions from these findings.

6.1.1. Summary of the documentary reviews

In summary, results from reviewing the policies addressing the major risk factors of NCDs namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity in South Africa and in Togo showed that, these policies have been formulated and implemented in both countries, with all the four risk factors addressed in South Africa and only three in Togo (unhealthy diet is yet to be addressed). In both countries, there was evidence of use of MSA in policy making process although more in formulation than in implementation. The number of sectors involved was high (more than four) in tobacco control policies and low (just two) in physical activity policies. On Alcohol, they were medium (3-4 sectors) in South Africa and low in Togo; and they were medium on Nutrition and Diet in South Africa. Lastly, in both countries the tobacco control policies are not fully WHO FCTC compliant and are yet to be fully implemented. For instance, in Togo, it was two years after the endorsement of the law that the implementation arrangements started with the issuance of five decrees. It took a year to translate these decrees into ministerial orders. As a result, it is only in September 1, 2014 that the implementation of the ministerial orders N°136 and 137 related to the health advertisements on the retailed unit started.

6.1.2. Summary of the findings from the Case studies

The Case studies focused on tobacco control policies because they were the ones with noticeable efforts in both countries. The findings of analysis of these cases with the study Framework for Multi-Sectoral Approach to Health Policy, through its major constructs of content, context, stakeholders and strategies can be summarised as follows:

With respect to content, the main findings were that South Africa and Togo have passed comprehensive national legislations on tobacco control, which are not fully compliant with the WHO Framework Convention on Tobacco Control[14] they both ratified in 2005: in South Africa the smoke free law allows for designated smoking areas instead of imposing a comprehensive ban on smoking in all public places as recommended in the WHO FCTC, and in Togo the health warnings were removed from the version of the law approved by the parliament.

In Togo, it was one bill passed in 2010, whereas South Africa required four incremental pieces of legislation between 1993 and 2009. In South Africa the main legislation is the Tobacco Products Control Amendment Act 1999 (No 12) that amends the 1993 Tobacco Products Control Act. It provides for: prohibition of smoking in enclosed public places, strong package warnings and health messages, prohibition of free distribution and gifts of tobacco products, prohibition of sale of tobacco to a person under the age of 16, regulation of vending machines and regulation of the contents of tobacco products. The 1999 Act empowers the Minister to promulgate as is necessary on matters relating to the Act. Both countries issued many regulations to put these laws into practice.

Political, historical, social and economic contextual factors were assessed in both countries, though not similar. Based on the economic context, South Africa is an upper middle-income country with tobacco leaf producers, firms and tobacco manufacturing companies, while Togo is a low-income country, only hosting some tobacco retailers. In South Africa, prior to 1993, the political, historical and social contexts of the tobacco control policy were characterised by a lack of government interest because the tobacco industry was dominated by white, Afrikaans-speaking South Africans with close ties with the "apartheid government." The change in political landscape with the first democratic elections in 1994, which brought into power Nelson

Mandela, enormously helped tobacco control cause in South Africa. Indeed, the African National Congress, the new ruling party, had no alliance with the tobacco industry and had much stronger commitment to an effective tobacco control policy since Nelson Mandela has consistently voiced his strong support for anti-smoking legislation and was on record as having called for a "world free of tobacco."[78] Likewise, Nkosazana Dlamini-Zuma, Mandela's minister of health, was known to be strong-willed and determined, and she was also on record of requiring smoke-free cabinet meetings.[78] In Togo, unlike South Africa, tobacco control was not an issue of "high politics," so it was relatively easy to merge the problem, policy and politics streams and convince the government to act.

Considering stakeholders, actors from the critical three sectors of the state-the public sector (government), private sector and civil society defined by George Alleyne[79] were involved in policy making on tobacco control in both countries. The government, through the Department of Health led the process in both countries and got supports from the civil society organisations to overcome barriers from the private sector. However, involvement and support of stakeholders from the research institutions and civil society organisations were more diverse, proactive and dynamic in South Africa than in Togo. Indeed, although the health department led the process in both countries, the research institutions and civil society organisations played a much greater role in South Africa than Togo. For instance, as early as 1988, a special "tobacco focus" issue was published in the South African Medical Journal to coincide with the first World No Tobacco Day.

The study found the strategies employed in tobacco control policy making more straightforward in Togo than in South Africa. Indeed, in a low political context, with readily available evidence provided to the Department of Health mainly by the WHO, it was possible for policy makers in Togo to overcome resistance from the representative of the tobacco and hospitality industry and got the Parliament to pass a tobacco control law compliant with the WHO Framework Convention on Tobacco Control. Conversely, the high political context in South Africa with stakeholders who have vested interests in blocking or weakening the tobacco control policies, the policy makers—led by the Department of Health and supported by the research institutions and

civil society—used a sound and steady combination of science, evidence and politics, including strong activism to succeed.

Results also showed that based on its operational definition of "involvement of any two or more sectors, one of which must be government" MSA was highly used in the formulation and implementation of tobacco control policies in South Africa and in Togo; more sectors were involved at the implementation than at the formulation stage; and the civil society organisations were highly involved although more in South Africa than in Togo. However, the process was led, in both countries, by the Department of Health instead of the cabinet or a supra-departmental commission, which did not permit significant interactions either among other departments of the government (whole of government) that have a stake in tobacco control policy making. Therefore, the extent of understanding and use of MSA in both countries was limited to an inter-sectoral action for health which is a narrow and minimal interpretations and scope of MSA. In the absence of such a whole of government approach[32], mainly information sharing, resulting in sub-optimal implementation of tobacco control policies in both countries was identified through the interaction between institutions and interest groups within and across three critical sectors of the state, namely public sector (government), private sector and civil society. In South Africa, local expertise through several scientific publications from research and academic institutions and a strong political will initially from the post-apartheid government were the most important facilitating factors both at the policy formulation and implementation stages, and they were higher than the ratification of the WHO FCTC. Conversely, in Togo, the WHO FCTC was the leading facilitator of the use of MSA in tobacco control policy making process. In both countries, the tobacco industries have been the main barriers to the formulation and implementation of tobacco control policies, but they are stronger in South Africa than in Togo because of their reported contribution to country revenues and their ties with the ruling power, particularly during the apartheid era.

6.1.3. Study Conclusion

In conclusion, the analysis, interpretation and discussion of data generated from both the documentary review and in-depth interviews of key informants permitted to address the 5 objectives of the study, and the key findings suggest that:

1. Health gains for NCDs can be achieved much more readily by influencing public policies in sectors like Trade, Taxation, Education, Agriculture, Urban development, Food and Pharmaceutical production than by making changes in health policy alone. In other words, addressing NCDs and their risk factors should be relevant to addressing socio-economic development factors by sectors outside health particularly in developing countries.

2. Only multi-sectoral, whole-of-government and whole-of-society responses are appropriate to simultaneously address the shared risk factors of NCDs and their underlying determinants such as residence, education, material well-being and access to health to health care. Indeed, it is stated in the preamble of the WHO Constitution that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". Health inequities defined as avoidable and unfair systematic differences in the health of population are rooted in the social determinants of health, which are the conditions in which people are born, grow up, live, work and age, as well as the systems put in place to deal with illness. Therefore, to improve the inter-sectoral understanding and use of MSA on tobacco control policies in South Africa and in Togo, this study recommend to move from an inter-sectoral action for health led by the Health Department to a multi-sectoral approach-whole of government-to health, managed by a national multi-sectoral mechanism at the cabinet level, which will ultimately improve policy coherence across government and yield significant progress toward sound formulation and implementation of comprehensive tobacco control policies. This conclusion is similar to the following one made by Shankardass and colleagues (2011)[57]: Health in All Policies approach is distinguishable from Inter-sectoral Action for Health and other inter-sectoral initiatives to advance health equity in two important ways:

- Firstly, "Health in All Policies" approaches are coordinated primarily by formal structures and mechanisms of governments – although they may include non-governmental actors, including those from academic, private, and community/civil sectors;
- Secondly, interventions adopted under "Health in All Policies" approaches are explicitly linked to supra-governmental policies or agendas, rather than being ad hoc in nature".

6.2. Contribution to existing knowledge: significance of the study

6.3. Suggestions for future research

Though NCDs are the leading causes of global death and disability, they attract less than 2% of the global health funding.[8] This study acknowledged and documented the importance a multi-sectoral approach to the formulation and implementation of policies addressing the four major modifiable risk factors of the four major NCDs and proposed a comprehensive framework for analysis. On one hand, it is important to apply this framework to other risk factors for diseases unrelated to tobacco use and in other sub-Sahara African countries; on the other hand, it is equally important to widen the scope of future research on the governance of multi-sectoral action for health discussed in this study. It is also important to research on the potential reasons why international funders systematically overlook the NCDs. The global agenda on sustainable developments[12] with its targets of reducing mortality from non-communicable disease and achieving universal health coverage and access to quality health services and medications, alongside other targets on poverty, gender equity, climate change, cities, and economic growth, constitute an important opportunity to advocate and mobilise funding for NCDs. Therefore, this study wishes to suggest further research on underlying determinants and economic cost of NCDs, by testing some of the following acknowledged, but poorly documented approaches[13]:

1) **Addressing MSA measurement issues**, including defining minimal involvement to be considered "active," the impact of multiple organizations within sector compared to a single organization within a sector, and (c) the number or kind of sectors that are most highly associated with effective and timely policy formulation and implementation.

2) **Improving the capacity of the health sector to work with other sectors** through learning from application of multi-sectoral approaches in public policy fields such as environmental protection, emergency management, land use planning and education.
3) **Reframing NCDs** with a compelling and simple narrative instead of defining them by what they are not
4) **Redefining the role of the health sector in NCDs control** e.g. by making the health sector a catalyst, rather than the driver for NCD control, using its privileged position of knowledge to sensitize other sectors on NCDs, and guide the integration of efforts into a comprehensive national NCD control policies, strategies and plans.
5) **Customizing the WHO tool kit for MSA** in formulating NCD prevention policies, strategies and plans, and adapting it for use in the country.
6) **Documenting the effectiveness and impact of the** various **interagency arrangements** utilised by WHO Member States to meet the health objectives of the multi-sectoral, whole-of-government, whole-of-society approach on policy issues of cross-departmental significance such as NCD risk factors and health inequities rooted into socio-determinants of health. Such arrangements include standing cabinet committees (chaired by the prime minister or the head of the state), members of parliament committees (for parliamentary scrutiny) or other supra-departmental commissions.
7) **Making NCD-affected individuals the centre of MSA efforts** and craft policies and actions responding to their articulated needs like it has been the case for HIV, TB and Malaria.
8) **Starting small** (e.g. with a defined sub-national jurisdiction in the country) and expanding efforts progressively to other jurisdictions. This may be more appropriate in countries like Kenya, Nigeria, South Africa and Togo with signed policies but not optimally implemented

Evidence from this study will help to develop cogent NCDs investment cases and thereby reduce the striking mismatch between global funding and the burden of the NCDs.

LIST OF APPENDICES:

Appendix 1: Summary of the coded transcripts of the key informants' interviews

Appendix 2: Key-informant interview guide, participant invitation and information sheet, and participant's consent form.

Appendix 2a: Key-informant interview guide, participant invitation and information sheet, and participant's consent form in English.

Appendix 2b: Key-informant interview guide, participant invitation and information sheet, and participant's consent form in French.

Appendix 3: University of Pretoria Ethics Committee approval letter

Appendix 4: Proof of article acceptance

Appendix 5: Curriculum Vitae

Appendix 1: Summary of the coded transcripts of the key informants' interviews

N°	Code	Gender	Sectors	Location	Dates of interviews (yyyy/mm/yy)	Transcripts paraphrased or quoted
1	S1	M	Civil Society Organisations	Johannesburg	2016/07/26	
2	S2	F	Civil Society Organisations	Johannesburg	2016/07/07	
3	S3	M	Civil Society Organisations	Johannesburg	2016/08/03	*'Each organization had their input such as sharing information while the department of health was responsible for the coordination'/CSO.*
4	S4	F	Civil Society Organisations	Pretoria	2016/07/27	
5	S5	M	Education	Pretoria	2016/07/29	
6	S6	M	Health	Germiston	2016/06/03	*'With the new government coming into power they realized that tobacco was a burden on the population and this made the government to take notice and formulate policies'; 'What went well was after 1994 the then minister of health Dr Nkosazana dlamini Zuma was taking the initiative and looked to reduce the consumption of tobacco products so she started to formulate policies and in 1999 the government passed the tobacco product control act. The minister introduces smoke free zones and introduced other policies and legislation to control tobacco use. In 2006 the policy was further strengthened by amendments'/Health 1.*

						'The national department of Health led the process in formulating the policies'; 'The NGOs had provided scientific evidence on the effects of tobacco while the department of health was bringing the whole group together'/Health 2
7	S7	M	Education	Pretoria	2016/06/07	
8	S8	M	Judiciary	Tzaneen	2016/06/29	
9	S9	M	Judiciary	Johannesburg	2016/07/14	*'as part of the law enforcement department, we are not involved at all this just comes from the government and we follows as required…. it's a pity we were not involved';….'I think the justice department should have been more involved in these processes because there are no speculated charges or penalties for those who don't abide or violate these tobacco control policies'/Police.* *'We feel we should have involved as the department of justice because as comply with the Act as it is formulated from the policy there are issues that we feel could have put across as a department. For instance, as the department of justice we feel that there are limitations in terms of rules as to how far does the law go in monitoring these policies'/Justice*

10	S10	M	Transport	Johannesburg	2016/07/14	
11	S11	M	Treasury	Pretoria	2016/08/15	
12	S12	F	Health	Pretoria	2016/08/16	*'The national department of Health led the process in formulating the policies'; 'The NGOs had provided scientific evidence on the effects of tobacco while the department of health was bringing the whole group together'/Health 2*
13	S13	F	Agriculture	Johannesburg	2016/08/23	
14	S14	F	Health	Pretoria	2016/08/22	
15	S15	F	Civil Society Organisations	Cape Town	2016/07/12	
16	S16	F	Law enforcement	Pretoria	2016/05/25	"*It's a pity we were not involved*"
17	S17	M	Civil Society Organisations making in SA)	Johannesburg	2016/06/28	*'Clearly you need to know what policies you want, then gather support both public and political this is an important element in South Africa because you need public support and political support so that they agree with what you are trying to do then you need NGOs to push for clear policies. When the ANC government came into governance Nkosazana Dlamini-Zuma was very supportive of fighting tobacco. She implemented the 1999 legislation banning the advertising. The tobacco industry in South Africa was very powerful and was led by Afrikaans speaking whites, so before this*

						they protected the tobacco industry. They argued that jobs would be lost however this was not true as we were able to prove this was false'/CSO.
18	S18	F	Civil Society Organisations	Johannesburg	2016/05/30	
19	S19	F	Health	Pretoria	2016/08/15	*'Taxation is not expertise that lie with the department of health and tobacco is a cross cutting issue we are just doing segments what we can do and historically the tobacco act has been developed and implemented from this department'/Health.*
20	S20	M	Civil Society Organisations	Pretoria	2016/09/08	
21	S21	F	The media	Pretoria	2016/09/09	
22	S22	M	Civil Society Organisations	Johannesburg	2016/09/07	
23	S23	M	Law enforcement	Pretoria	2016/09/01	
24	S24	M	Research institutions	Pretoria	2016/07/16	*'the taxation is a major intervention in South Africa however the implementation of that has not been very good in recent times like in the 90s they would increase so much more than inflation but now they are keeping it within inflation'/Academic.* *'Historically, it comes from advocate who*

						agitate for government response to what is happening in terms of what is no-regulation of tobacco. I am talking the debates that happened in the early 90"s and the publications from scientists who studied the content of tobacco particularly in 1988 the first No Tobacco Day there was a special edition of the South African Medical Journal (SAMJ)that featured a number of articles on tobacco. The health effect of tobacco, the economic effect of tobacco and I believe that captured the need for policy. However nothing happened until Nelson Mandela, I must say there was also a regional meeting in1993 that further articulated the policy options that meeting was further attended by Medical Research Council (MRC) the then minister of health Dr Nkosazana Dlamini-Zuma she used to work at the MRC she also attended the Harare meeting as a scientist working at the MRC she then became a minister in 1994. Coming from that there was a sense that the health desk of the African National Congress (ANC) was sensitized to articulate the policy of tobacco use in South Africa. Now the publication SAMJ that also provided the benefit of the policy like increasing taxes to

						include generating revenue to government seemed to have merged together with the interest to protect health. So now we can generate revenue and protect health, we coming in as a new government and we need money to move our social agenda I think that made Mandela to make an announcement to say he would regulate tobacco when he becomes president that was even before he even became president'/Academic.
25	S25	F	Civil Society Organisations	Cape Town	2016/05/21	
26	S26	F	The media	Pretoria	2016/05/20	*'I don't recall of a time or an opportunity where media people were necessarily involved in formulation of such policies'….'I believe media industries were involved* ***mostly in complying with these policies by abiding to rules and regulations on how not to publicize tobacco products through our platforms'/Media.***
27	T1	M	Trade & Transport	Lome	2016/05/27	
28	T2	M	The media	Lome	2016/06/10	
29	T3	F	Finance/Treasury	Lome	2016/06/30	
30	T4	M	Finance/Treasury	Lome	2016/06/13	
31	T5	M	The media	Lome	2016/06/08	
32	T6	M	The media	Lome	2016/06/29	

33	T7	M	Law enforcement	Lome	2016/06/17	
34	T8	F	Agriculture	Lome	2016/06/14	
35	T9	M	Finance/Treasury	Lome	2016/05/30	*'For me on fiscal basis there are issues managed by the ECOWAS which we have not totally integrated yet. Our policy on fiscal harmonization is more focus on decisions made at the UEMOA level, whereas at the ECOWAS level, the level of taxation is high. And we have not yet taken into considerations decisions from ECOWAS in the specific context of tobacco control. But the thinking is ongoing within the UEMOA because the issue was tabled. Should Member States of the UEMOA stay where they are, while other States in the sub-region have a more coercive policy? I know suggestions were made and we are waiting for a call for a general meeting to think about the latest decisions to take in the context of tobacco control'... Hmm, I give an example to illustrate perhaps my idea. When we were contacted by the department of health and there was a sensitization meeting, the tobacco industry did not fold their arms. They wrote to us to make counter-propositions with reference to studies whose conclusions were in opposition to what the department of health said. One of the conclusions of these studies,*

						which I recall, is whenever a country tries to control tobacco use, illicit trade definitely takes place. And since countries like Togo are not able to control all their borders, for them, adopting a tobacco control policy in Togo means encouraging illicit trade. And they had figures with examples from some countries. Another conclusion is that they were ready to increase the price of cigarette up to certain level as a result of discussion with the country. But that was a way of dissuading us from following what the department of health is saying. *But I confess that they were out of game vis-à-vis what we had already adopted within our unit'…« There may be some perspective in that fight. I am sure there are lot things going on. But the way we started with the sensitizations, considering other undertakings of all of us, I believe it should continue because whatever we say the tobacco industry will always exist. With all the information we received, it is not envisaged that a decision will be made towards closing tobacco industry. They exist and will always exit. They will have their benefits, their margins and all of that. But what are the perspectives? We need to be informed of all*

						these to allow the fight to continue. In the meantime, I told you the UEMOA and ECOWAS are working together to see in the context of fiscal system, what could be the perspectives. There also I think it is slow. For me, we should be able to act in such a way that this fight becomes a daily fight and the health of the everyone, in any case, of the population is protected'/Treasury/Togo"
36	T10	F	Trade & Transport	Lome	2016/05/13	
37	T11	F	Education	Lome	2016/06/28	
38	T12	M	Judiciary	Lome	2016/05/04	*'That is what I had told you. I was not involved in the formulation of the law passed. Since the national tobacco control committee is only within the department of health, I told you that it is because I participated in a meeting in Botswana; otherwise, I do not know how the law was formulated, if the justice had shared their viewpoints about the infractions mentioned in the law. Thus, I think it is during the implementation of this law that the justice is approached just to implement the law'/Justice.*
39	T13	M	Judiciary	Lome	2016/05/12	
40	T14	M	CSO*	Lome	2016/06/23	
41	T15	M	Legislature	Lome	2016/06/30	

42	T16	F	Law enforcement	Lome	2016/07/04	*'No I was not involved in the formulation of these policies, but we are trying to implement them ;… we were trained, we participated in the awareness meetings according to these laws. And on the ground, we apprehend those who breach the law'/Police.*
43	T17	M	Education	Lome	2016/07/01	*'In Togo foreigners smoke a lot; however, we need them for country development. And more, there is democracy, freedom of movement of people and goods which make difficult to control the use of tobacco in the countries, not only in Togo. Now there is pressure from the tobacco industry. They are powerful people, clever, very strong who easily manage to corrupt. That is it!'/Education.*
44	T18	M	Law enforcement	Lome	2016/06/10	
45	T19	M	Health	Lome	2016/06/23	
46	T20	M	Law enforcement	Lome	2016/06/08	
47	T21	M	Health	Lome	2016/04/26	*'As a coordinator (of the national tobacco control committee) we were somehow the « peacemaker ». It us who trigger the process and we produced, within a team with legal experts of the department of health, a draft which we shared with other departments of the government to check if the content of the draft*

						is agreeable to them;…the department of health is the one that coordinates, monitor and evaluate. The other departments check the applicability in their domains. For example, the department of justice checks if the proposed measures are in line with the constitution. The department of security checks if the measures, related to penalties for non-compliance, are agreeable to them. The department of trade checks if the proposed taxes are in line with their regulations' Health. 'The problem is that the tobacco industry did not want any policy on tobacco control and tried their best to block the law. But the Togo's authorities chose the health of the population and the law was passed; it is the tobacco industry that corrupts and precludes people from fulfilling their mission'/health
48	T22	M	Health	Lome	2016/04/26	
49	T23	M	Health	Lome	2016/04/29	
50	T24	M	CSO*	Lome	2016/05/02	*'It is mainly the commitment from WHO through its representative in Togo that helped get support for the development of some plans. In addition, during their meeting in Bangui, CAR, the ministries of health from Africa took a firm resolution to combat NCD with a priority on tobacco control,… It is also worth*

						noting that the conference of parties on FCTC wherein each party should report progress every two years. This obligation precludes countries to stay behind and every country is willing to share with the world what it is doing'/CSO. *'It was not easy to get approval of cabinet decrees by all the ministers of the government because they were defending the interests of their departments. When it was about taking a ministerial order against the tobacco industry the department of trade was not in favor because for them the tobacco industry is an important source of income for the country;….When we started the campaign for ratification (of the FCTC) there was a delegation which came to complaint about the losses that will result from taxation of tobacco products. They said taxation on tobacco brings so far up to 5 billion XOF (about 10 million USD) to the country revenue and thereby a more coercive policy will yield important revue losses. Then we were asked by the parliament about how such deficit will be filled? We were obliged to convince member of the parliament with arguments from the health perspective,*

						especially by saying that it will cost at least 8000 Euro per person to treat disease from tobacco use. Then the tobacco industry wanted to block the vote by the parliament, but they realized that they cannot. But that is why an important element that is health warning pictures was withdrew from the law passed. Because of ***interferences*** *from tobacco industry implementation of the law was delayed for one year. Till date they still oppose the law on total ban on advertisement. A movie was produced by John Olivier on how the tobacco industry interferes in the tobacco control policies' /CSO/Togo.* *'When we started the campaign for ratification (of the FCTC) there was a delegation which came to complaint about the losses that will result from taxation of tobacco products. They said taxation on tobacco brings so far up to 5 billion XOF (about10 million USD) to the country revenue and thereby a more coercive policy will yield important revue losses. Then we were asked by the parliament about how such deficit will be filled? We were obliged to convince member of the parliament with arguments from the health perspective, especially by saying that it will cost at least*

						8000 Euro per person to treat disease from tobacco use. Then the tobacco industry wanted to block the vote by the parliament resulting, but they realized that they cannot. But that is why an important element that is health warning pictures was withdrew from the law passed. Because of interferences from tobacco industry implementation of the law was delayed for one year. Till date they still oppose the law on issues total ban on advertisement. A movie was produced by John Olivier on how the tobacco industry interferes in the tobacco control policies' /CSO/Togo.
51	T25	M	Tobacco retailers	Lome	2016/05/03	
52	T26	M	Law enforcement	Lome	2016/05/*06*	*'I do not have the proof, but I heard that it was not easy to pass the law because of the lobbying from the tobacco industry. Their actions lead to changing some elements of the text'/law enforcement.* *'I was not really involved. They did not call for a meeting during the formulation of the policy.* ***It is after the law was passed that the national anti-drug committee were approached to see how the law enforcement can contribute to its implementation****, because they are in charge of controlling all drugs;…we just abide by the*

						law as it was passed. We do not have a view to share. What to do is to limit from all the ports of entrance the influx of tobacco in the country. The more people are involved in, the more it succeeds. If I were involved in the formulation of the law I would have included some of the aspects of the fight against tobacco in the fight against drugs. I would have also shared my experience on the fight against drugs'/Law enforcement
53	T27	M	CSO*	Lome	2016/05/10	
54	T28	M	Tobacco retailers	Lome	2016/05/23	
55	T29	M	CSO*	Lome	2016/05/23	*'The lobbying of the tobacco industry effectively constitutes a barrier to our actions. Since Togo' authorities are looking for money, they are often ready to consider any offer regardless of the source of the money. Otherwise, how can you understand that it is forbidden to smoke in the public places and when there is an authority (VIP) nothing is said? If anybody complains the authority should do so'/CSO*
56	T30	M	Law enforcement	Lome	2016/06/08	*Besides being a signatory of the FCTC, the government of Togo can take more coercive legislative measures based on the treats faced by the country. The tobacco control law in*

						Togo is derogatory to general principles. For instance, according to justice, tobacco products on transit cannot be seized. But we know that if we do not seize them they will come back to Togo market. Therefore, it is a mix of measures that are taken to preclude tobacco products on transit to come back here. In the Togo legislation, we are more in the logic of prevention. ***We want to avoid products being dumped in the country'/Law enforcement.*** *'Togo has ratified a number of conventions and to abide by these conventions, there was a need to align national laws and regulations with the global commitments. In the particular case of tobacco, efforts have been made because of the influx of tobacco in our territory. Togo is not a tobacco producer, but there are people who export tobacco because we have a highly competitive sea port. Therefore, dubious businessmen use our territory for their business. They order large quantity of cigarettes and other tobacco products and put them on transit via Togo. When the products arrive, they cannot be taxed and they fall out of the control of law*

						enforcement officers and they end up in the local market without any taxes and these businessmen make a lot of profit. The more the supply of the market is high the less the price of the product and this encourages consumers who do not have enough financial resources. Around the end 2015-early 2016 there were recurrent seizures of tobacco products particularly in the sea port, which yield more awareness to the authorities and thereby issuance of a ministerial order'/ Law enforcement

*Civil Society Organisations

Appendix 2: Key-informant interview guide, participant invitation and information sheet, and participant's consent form.

Appendix 2a: Key-informant interview guide, participant invitation and information sheet, and participant's consent form in English.

University of Pretoria
Faculty of Health Sciences
School of Health Systems & Public Health

Study Title: Assessment of the Multi-sectoral Approach (MSA) to Non-Communicable Diseases (NCD) Prevention Policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016.

KEY INFORMANTS INTERVIEW GUIDE

Introduction

Good (morning/afternoon/evening), My name is _____; I am a PhD student at the University of Pretoria. Today I will be conducting research to ***analyse tobacco control policies in SA.***

This study aims to determine the extent to which Multi-Sectoral Approach (MSA) has been used in the formulation of public policy on tobacco control in SA. Tobacco use is the world largest preventable cause of illness and death. It is the most important risk factor for Non-Communicable Diseases (NCDs), particularly cardiovascular and chronic respiratory diseases (high blood pressure, congestive obstructive pulmonary disease and lung cancer)

For this study, our focus is on the population level interventions aimed at eliminating or reducing consumption of tobacco products and exposure to tobacco smoke in SA.

In particular, we would like to understand who and which sectors have been involved with tobacco control policy development and implementation in SA.

In terms of policy, we are interested in higher level policies such as laws, regulations, national strategic plans, as well as lower level policy guidelines and action plans related to tobacco control and program implementation strategies.

To obtain reliable information we request that you answer the questions that follow as frankly as possible. Your views are important in this research. There is no right or wrong answer. It is your knowledge and opinion that count. The information you give to us will be kept confidential. You will not be identified by name or address in any of the reports we plan to write.

The interview will take 45-60 minutes

PLEASE REQUEST INFORMED CONSENT

Demographics, TAKE NOTES (identifying information to be kept separate from interview transcripts)

Just to confirm that I have your right details (USE THE SEPERATE FORM TO COMPLETE THE INFORMATION BELOW)

a. Participant's name & organization and email/ contact details (fill in beforehand if possible):

b. Participant's title/designation and primary responsibilities:

c. What year did you start working in this organization? What year did you start in this particular position?

REQUEST TO TURN ON RECORDERS AT THIS POINT

Tobacco control Policies

A. Policy Context & Content

1. Which tobacco control policies are you aware of in this Country?
2. What was the rationale for formulating the tobacco policy?
    a. How was the problem defined, brought on the political agenda?
    b. How were the policies options developed?
3. What issues led to the development of the tobacco policy (*For each policy mentioned :)*

    b. What issues **within SA context** led to the development of the policy (*Probe for: whether there were political changes, health sector reforms, organizational changes, fiscal policies, and changes in government*

    c. What at the **Global level** influenced the formulation of tobacco control policies ***(****probe for global movements, declarations, meetings)*

B. Actors in Policy formulation

4. To what extent were you involved in the formulation of these tobacco policies? (*Probe for each policy mentioned)*

a. What was your role in the formulation of the tobacco policy

b. Please describe your experience as you participated in the formulation of the policy (*What in your opinion went well? What could have been done differently?)*

5. Which other sectors (governmental and non-governmental sectors) were involved in the formulation of the policies

a. Which sectors or inter-sectoral governance structures led the process in formulating the tobacco policies?

b. What was the role of the sectors or structures that were involved?

- Evidence support
- Setting goals & targets
- Coordination
- Advocacy
- Monitoring & Evaluation
- Policy guidance
- Financial support
- Providing legal mandate
- Implementation & management

c. Who else should have been involved in your view and why?

- Why do you think they were not involved?
- *How in your view would their involvement have shaped or influenced the policy*?

d. What strategies were used to bring the different stakeholders/sectors to work together in formulating these tobacco policies (e.g. Information sharing, cooperation, coordination or integration)?

e. What were the benefits of involving many actors in policy development processes?

f. What were the challenges encountered in bringing the different sectors together in formulating the tobacco policies?

g. To what extent were women's groups, NGOs, representatives etc involved in the formulation of the policy?

C. Policy Implementation

6. To what extent have the tobacco policies been implemented (*probe for each policy mentioned?)*

a. How were you involved in the implementation of the tobacco policies?

b. Which other sectors/ stakeholders were involved in the implementation of the policies?

c. What inter-sectoral governance structures were involved in implementing tobacco control policies (Cabinet committee, Parliamentary committee, interdepartmental committee, Joint budgeting, Delegated financing, Public engagement, stakeholder engagement, industry engagement)

d. What types of interventions on tobacco control are developed? (Upstream, Midstream or Downstream)

e. What is the coverage of these interventions (horizontal/universal or vertical/target)?

f. Was an impact assessment conducted? (Y/N)

g. If yes what type of impact assessment, (e.g. STEPS, HIA, HEIA)

h. Who else should have been involved and yet they were not involved in implementing the policy (Private sector, civil sector, academic sector etc.)?

   i. Why do you think they were not involved?

   ii. What in your view would have been the impact on the policy if they had been involved?

i. What management and control strategies were used in implementing the tobacco policies (top-down vs bottom-up, horizontal vs vertical integration)

j. What factors enabled different sectors to work together in implementing these tobacco policies

k. What were the challenges encountered in implementing the tobacco policies *(Probe for challenges in bringing several sectors together to support implementation)*

7. Please comment on how tobacco industry influenced the tobacco policy development process *(negatively or positively).*

    a. How did you overcome any challenges that industry interference may have generated?

8. What kind of funding is available for implementation of the tobacco policies mentioned?

Probe: For amount of funding; Sources of funding)

Probe: Are there arrangements such as joint budgeting and delegated financing aimed at addressing tobacco issues?

9. What factors in your view facilitate the working together of different sectors in formulating /implementing tobacco policies?

Probe for recommendations to facilitate different sectors in working together in implementing of tobacco programs?

    a. *What factors in your view hinder the working together of different sectors in formulating/implementing tobacco policies?*

Is there anything else significant about the development Tobacco control policy /program in Togo that we have not discussed so far?

Ask for relevant documents and names of other potential respondents.

Thank you for participating in this study. Your responses will be very helpful to our understanding of Tobacco control policies and how to enhance MSA in developing the policies

This is the end of our discussion today.

University of Pretoria
Faculty of Health Sciences
School of Health Systems & Public Health

Study Title: Assessment of the Multi-sectoral Approach (MSA) to Non-Communicable Disease (NCD) Prevention Policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016.

Participant Invitation and Information sheet

Invitation to participate in the study

You are being invited to participate in the above-mentioned study conducted by the Faculty of health Sciences of the University of Pretoria.

The purpose of the study

The purpose of this study is to determine the extent to which Multi-Sectoral Approach (MSA) has been used in the formulation of public policy on tobacco control in SA. Multi-sectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health-related outcomes or the determinants of health or health equity. These include actions within and between sectors, at the local, regional, provincial, national, and global levels, that are needed to influence the social and economic landscape that enables the health and well-being of the population.

Tobacco use is the world largest preventable cause of illness and death. It is the most important risk factor for Non-Communicable Diseases (NCDs), particularly cardiovascular and chronic respiratory diseases (high blood pressure, congestive obstructive pulmonary disease and lung cancer.) Our focus is on the population level interventions aimed at eliminating or reducing consumption of tobacco products and exposure to tobacco smoke in SA.

Your participation

We are asking you to participate in a one-on-one interview to share your perspectives and experiences about Tobacco control policy formulation and implementation in Togo and the involvement of different sectors in these processes. The interview will take about 45 -60 minutes.

Your participation in this study is **voluntary**, and you can choose **not** to participate without suffering any negative consequences. Please note that if at any point in time you feel you do not want to continue participating, you can withdraw. If at any point you feel uncomfortable about any of the questions, you do not have to answer them. During the interview, the researchers will take notes and make an audio recording of the conversation. The interviews will be in English.

Confidentiality

We would like to assure you that any information you share will remain strictly confidential. The information will be used only for the purpose of the study and your confidentiality will be protected. Nothing that you tell us today will be shared with anybody outside the research team. Anonymity will be protected by not recording your name with your responses or identity in any way. A unique code number will be assigned to you to identify your taped interview and interview transcripts. Your institution will also have a unique code and the name will not be used in presenting results. Your identity will not be revealed in any reports or publications emerging from this study. You can also choose to withdraw your quotes at any time. Although your name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not you participated in this study.

The audio-recorded information will be extracted from the recorders and then deleted. The accompanying notes will be locked in cabinets only accessed by the research team and will also be discarded once the study is completed.

Risks to participating

There is no anticipated risks/harm that you will suffer for participating in this study. If any questions do cause you discomfort or unease, you have the right to choose not to answer these questions. We will take the necessary steps to protect your confidentiality, as we have described below. It is important for you to know that you can choose not to take part in the study and a decision not to participate will not have any negative consequences for you.

Benefits to participating in this study

There are no immediate direct benefits to you from participating in this study. However, this study will be extremely helpful in promoting the understanding and applying of the multi-sectoral approach in the design and implementation of Tobacco control policies in SA.

If you would like to receive feedback on our study, we will record your contact details on a separate sheet of paper and can send you the results of the study when it is completed sometime in three years.

Ethics

This study has been approved by the Health Sciences Faculty Ethics Committee of the University of Pretoria. You have the right to ask, and I will answer any questions you may have about this research. If you have further questions about the study or the results, about your rights as a research participant, or concerns or complaints about the research, you may contact **Dr. Saliyou Sanni** at University of Pretoria at u15023363@tuks.co.za & sasanni@yahoo.fr.

When to participate

If you are interested in participating in the study, we will call to schedule an interview time that is convenient for you. If you choose to participate in the interview, you will be asked to complete the written consent form that will be given to you prior to beginning the interview.

Thank you for your valuable contribution to our research study. If you have questions or would like additional information, please do not hesitate to contact me.

Sincerely,

Dr. Saliyou Sanni

PhD Candidate

University of Pretoria

Tel: +27 (0) 63 499 7161

Email: u15023363@tuks.co.za or sasanni@yahoo.fr

University of Pretoria
Faculty of Health Sciences
School of Health Systems & Public Health

Study Title: Assessment of the Multi-sectoral Approach (MSA) to Non-Communicable Disease (NCD) Prevention Policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016.

Participants Consent:

Participants Code Number…….

I have understood to my satisfaction the information regarding the study and my participation in the research project.

I (*please print your name*): _____, agree to participate in the above-mentioned research study

I agree to allow my interview to be audio-taped: □ Yes □ No

I agree to be quoted: □ Yes □ No

Participant's Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Appendix 2b: Key-informant interview guide, participant invitation and information sheet, and participant's consent form in French.
Université de Pretoria

Faculté des Sciences de la Santé
Ecole des Systèmes de Santé et de la Santé Publique

Intitulé de l'étude : Evaluation de l'utilisation de l'Approche Multisectorielle (AMS) dans les politiques de prévention des Maladies Non Transmissibles (MNT): études de cas sur les politiques de contrôle du tabac au Togo et en Afrique du Sud de 2014 à 2016.

GUIDE DE L'INTERVIEW DES PERSONNES RESOURCES

Introduction

Bonjour/Bon-après-midi/Bonsoir, Mon nom est _____; Je suis un Doctorant en Systèmes de Santé à l'Université de Pretoria. Aujourd'hui, je voudrais vous interviewer dans le cadre d'une étude sur **l'analyse des politiques de control du tabac au Togo**.

L'objet de l'étude est de déterminer dans quelle mesure l'Approche Multisectorielle (AMS) a été utilisée lors de la formulation des politiques de control du tabac au Togo.

La consommation du tabac est le plus important facteur de risque de Maladies Non-Transmissibles (MNT), particulièrement des maladies cardiovasculaires et des maladies respiratoires chroniques (hypertension artérielle, pneumopathie congestive et obstructive et cancer du poumon).

Notre focus dans le cadre de cette étude est sur les interventions de santé publique visant à éliminer où à réduire la consommation de des produits dérivés du tabac et l'exposition à la fumée du tabac au Togo.

En particulier nous voulons savoir qui et quels secteurs ont été impliqués dans la formulation et la mise en œuvre des politiques de control du tabac au Togo.

En matière de politiques, nous sommes intéressés aussi bien par les politiques élaborées aux hauts niveaux telles que les lois, les régulations, les stratégies et plans, que par celles relatives aux directives et plans d'actions en matière de control du tabac.

Afin d'obtenir des informations fiables nous sollicitons que vous répondez aux questions suivantes le plus honnêtement possible. Vos points de vus sont importants dans le cadre de cette étude. Il n'y a pas de bonne ou mauvaise réponse. Ce qui compte est de partager votre connaissance et opinion. Les informations que vous allez partager avec nous seront considérer

comme confidentiel. A cet effet, vous ne serez pas identifier par votre nom ou adresse dans aucun des rapports ou publication découlant de cette étude.

Cette interview durera entre 45-60 minutes.

PRIERE SOLLICITER LE CONSENTEMENT ECLAIRE

Données démographiques, PRENDRE NOTES (identifier les informations à séparer de la transcription de l'interview)

Juste pour m'assurer que j'ai bien note votre adresse. (UTILISER UNE AUTRE FEUILLE POUR COLLECTER LES INFORMATIONS CI-DESSOUS)

d. Nom du participant & organisation and email/ adresse (à remplir à l'avance si possible):

e. Titre/fonction/position du Participant et responsabilités premières:

f. En quelle année avez vu commencé à travailler dans cette organisation? En quelle année avez-vous commencé à exercer cette fonction?

RESOLLICITER L'AUTORISATION DE COMMENCER L'ENREGISTREMENT DE L'INTERVIEW A PARTI DE CET INSTANT

Politiques de control de la consommation du tabac

A. Contexte & Contenu de la Politique

8. e quelles politiques de contrôle du tabac au Togo êtes-vous au courant?

9. Quel était la raison/motivation de la formulation de politique de contrôle du tabac?

    a. Comment le problème a été défini et inscrit dans l'agenda politique?

    b. Comment ont été développées les options de politiques?

10. Quels sont les problèmes/défis qui ont conduit à l'élaboration de la politique de control du tabac (*Pour chacune des politiques mentionnées :)*

    d. Quels sont les problèmes/défis **dans le contexte du Togo** qui ont conduit à l'élaboration de la politique de control du tabac (*Rechercher: d'éventuels changements politiques, reformes du secteur de la santé, changements organisationnels, politiques fiscales, et changements dans le gouvernement*

    e. Quel évènement du **niveau mondial** a influencé l'élaboration de politiques de contrôles du tabac *(Rechercher mouvements, déclaration, réunions mondiaux)*

D. Acteurs de l'élaboration de la politique

11. Quel a été votre degré d'implication dans l'élaboration de ces politiques de contrôle du tabac? (*Poser la question pour chacune des politiques mentionnées)*

c. Quel était votre rôle dans l'élaboration de cette politique ?

d. SVP décrivez votre expérience de participants à l'élaboration de cette politique ? (Selon vous qu'est-ce qui a bien fonctionné*? Qu'est-ce qui aurait pu fait autrement?)*

12. Quels autres secteurs (gouvernementaux et non-gouvernementaux) étaient impliqués dans l'élaboration de ces politiques ?

h. Quels secteur or structure intersectorielle et gouvernementale a assuré le leadership du processus d'élaboration des politiques de control du tabac au Togo?

i. Quel a été le rôle des secteurs ou structure qui ont été impliqués?

- Mise à disposition des évidences
- Formulation des objectifs et cibles
- Coordination
- Plaidoyer
- Suivi & Evaluation
- Guidance politique
- Appui Financier
- Facilitation de l'obtention d'un mandat légal
- Gestion de la mise en œuvre

j. Selon vous quels autres secteurs ou structures auraient dû s'impliquer et pourquoi ??

- Selon vous pourquoi ces secteurs ou structures n'ont pas été associées/impliquées?
- *Selon vous comment leurs implications auraient contribuées ou influencer la politique*?

k. Quelles ont été les stratégies utilisées pour amener les différents parties/secteurs à travailler ensemble pour élaborer ces politiques en matière de contrôle du tabac (e.g. partage d'information, coopération, coordination ou intégration)?

l. Quelles ont été les bénéfices de l'implication de plusieurs acteurs dans le processus d'élaboration de ces politiques?

m. Quels ont été les défis rencontrés du fait d'amener les différents parties/secteurs à travailler ensemble pour élaborer ces politiques en matière de contrôle du tabac?

n. Dans quelle mesure les associations de femmes, les représentants d'ONGs etc. ont été impliqués dans le processus d'élaboration de ces politiques?

E. Mise en œuvre de la politique

13. Dans quelle mesure les politiques de contrôle du tabac ont été mise en œuvre (Poser la question pour chacune des politiques mentionnées*?)*

l. Comment avez-vous été impliqués dans la mise en œuvre des politiques de contrôle du tabac?

m. Quels autres secteurs/parties prenantes étaient impliqués dans la mise en œuvre de ces politiques ?

n. Quelles structures intersectorielles et gouvernementales étaient impliqués dans la mise en œuvre des politiques de control du tabac? (conseil de gouvernement/primature, Comités Parlementaires, comités interdépartementaux, budgétisation conjointe, financement délégué, engagement du public, engagement des parties prenantes, engagement des industries)

o. Quels types d'interventions de control du tabac ont été développées? (Upstream/holistique de niveau national, Midstream/ciblés or Downstream/localisés)

p. Quelle est le niveau de couverture de ces interventions (horizontale/universelles ou verticales/ciblées)?

q. Est-ce qu'une évaluation d'impact a été réalisée? (Oui/Non)

r. Si oui quel type d'évaluation d'impact, (e.g. STEPS, HIA, HEIA)

s. Qui d'autres auraient dû, mais n'ont pas été impliqués dans la mise en œuvre des politiques de contrôle du tabac (secteur privé, société civile, milieu académique etc..)?

iii. Selon vous pourquoi ces secteurs ou structures n'ont pas été associées/impliquées

iv. *Selon vous comment leurs implications auraient contribuées ou influencer la politique*?

t. Quelles ont été les stratégies de gestion et de control utilisées pour mettre en œuvre les politiques de contrôle du tabac (top-down versus bottom-up, horizontale vs verticale, intégration)

u. Quels ont été les facteurs qui ont permis aux différents parties/secteurs à travailler ensemble pour la mise en œuvre de ces politiques ?

v. Quelles ont été les défis rencontrés lors de la mise en œuvre de ces politiques *(Explorer les défis liés à amener plusieurs secteurs à œuvrer ensemble pour l'appui à la mise en œuvre)*

14. SVP Faites un commentaire sur comment l'industrie du tabac a influencé le processus d'élaboration des politiques de control du tabac *(négativement ou positivement).*

a. Comment avez-vous surmonté ces défis liés aux interférences de l'industrie du tabac?

8. Quel type de financements disponibles pour la mise en œuvre des politiques sus mentionnées en matière de de control du tabac?

Rechercher: montant des financements; Sources du financement)

Rechercher: Existence d'arrangements/mécanismes du type budgétisation conjointe et financement par délégation visant à résoudre les problèmes liés au tabac?

9. Selon vous quels facteurs ont permis d'amener différents secteurs à travailler ensemble pour élaborer et mettre en œuvre ces politiques?

Rechercher : recommandations qui ont facilité différents secteur à travailler ensemble pour la mise en œuvre des programmes de contrôle du tabac?

10. Selon vous quels facteurs ont empêché/freiner le travail ensemble des différents secteurs dans la formulation/mise en œuvre des politiques de contrôle du tabac?

Est-ce qu'il y a quelque chose d'important sur l'élaboration des politiques de control du tabac au Togo que nous n'avons pas abordé ?

Pourriez nous indiquer les documents à consulter et les noms d'autres personnes qu'il faut interviewer ?

Merci pour votre participation à cette étude. Vos réponses seront utiles pour notre compréhension des politiques de contrôles du tabac et du comment renforcer l'approche multisectorielle lors de l'élaboration des politiques.

Ceci est la fin de notre entretien.

Université de Pretoria
Faculté des Sciences de la Santé
Ecole des Systèmes de Santé et de la Santé Publique

Intitulé de l'étude: Evaluation de l'utilisation de l'Approche Multisectorielle (AMS) dans les politiques de prévention des Maladies Non Transmissibles (MNT): études de cas sur les politiques de contrôle du tabac au Togo et en Afrique du Sud de 2014 à 2016.

Fiche d'invitation et d'information du participant

Invitation à participer à l'étude

Vous êtes invite à participer à l'étude susmentionnée conduit by par la Faculté des Sciences de la Santé de l'Université de Pretoria.

Objet de l'étude

L'objet de l'étude est de déterminer dans quelle mesure l'Approche Multisectorielle (AMS) a été utilisée lors de la formulation des politiques de control du tabac au Togo. On entend par Approche Multisectorielle (AMS) pour la santé toutes les actions entreprises par des secteurs autres que celui de la santé, possiblement, mais pas nécessairement, en collaboration avec le secteur de la santé, sur la santé, les résultats de santé, les déterminants de la santé ou l'équité en matière de santé. Ces actions comprennent des actions intra et intersectoriels au niveau local, régional, provincial, national et mondial nécessaires pour influencer l'environnement social et économique favorable à la santé et au bien-être des populations

La consommation du tabac est la plus grande cause évitable au monde de maladies et de décès. Elle est aussi le plus important facteur de risque de Maladies Non-Transmissibles (MNT), particulièrement des maladies cardiovasculaires et des maladies respiratoires chroniques (hypertension artérielle, pneumopathie congestive et obstructive et cancer du poumon). Notre focus dans le cadre de cette étude est sur les interventions de santé publique visant à éliminer où à réduire la consommation de des produits dérivés du tabac et l'exposition à la fumée du tabac au Togo.

Votre participation

Nous sollicitons votre participation à cette interview pour recueillir vos perspectives et expériences à propos de la formulation et de la mise en œuvre des politiques de control du tabac au Togo ainsi que l'implication des autres secteurs dans le processus. Cette interview durera entre 45-60 minutes.

Votre participation à cette étude est volontaire et vous pouvez choisir de ne pas participer sans courir aucun risque de conséquences négatives. Sachez, SVP que vous pouvez renoncer à votre participation à tout moment dès que vous ne voulez plus. Si vous n'êtes pas à l'aise avec une des questions, vous n'êtes pas obligés d'y répondre. Au cours de l'interview les membres de l'équipe de recherche vont prendre note et enregistrer la conversation. L'interview sera en Français.

Confidentialité

Nous vous rassurons que toutes les informations que vous allez partager avec nous resterons strictement confidentielles. Ces informations seront utilisées uniquement pour les besoins de cette étude et votre confidentialité sera protégée. Aucune des informations que vous avez partagées avec nous ne sera communiquée à d'autres personnes en dehors des membres de l'équipe de recherché. L'anonymat sera protégé en n'enregistrant pas votre nom avec vos réponses ou votre identité. Un code unique vous sera attribué pour identifier la cassette d'enregistrement et de transcription de votre interview. Un autre code sera attribué à votre institution et le nom de l'institution ne sera pas utilisé lors de la présentation des résultats. Votre identité ne sera pas révélée dans aucun des rapports ou publications découlant de cette étude. Vous pouvez à tout moment décider de retirer vos citations. Quoique votre nom soit communiqué aux membres de l'équipe de recherche par une autre personne contacte, les membres de l'équipe de recherche ne vont pas révéler à cette personne si vous avez participez ou pas à l'étude. Une fois les informations extraites de la cassette d'enregistrement, elles seront effacées de ladite cassette. Les notes prises lors de l'interview seront verrouillés dans une armoire à laquelle seuls les membres de de l'équipe de recherche ont accès et seront aussi détruites à la fin de l'étude.

Risques liés à votre participation

Il n'y pas de risques/nuisances potentiels encourus du fait de votre participation à cette étude. Si vous n'êtes pas confortable ou à l'aise avec certaines question vous avez le droit de ne pas y répondre. Nous prendrons toutes les dispositions nécessaires pour protéger votre confidentialité comme ci-dessus décrit. Il est important que vous sachiez que vous pour pouvez choisir de ne pas participer à cette étude et que cette décision ne vous fait courir aucun risque de conséquences négatives.

Bénéfices liés à votre participation

Il n'y a pas de bénéfices directs immédiats liés à votre participation à cette étude. Toutefois, cette étude sera extrêmement utile pour la promotion de la compréhension et de la mise en application de l'approche multisectorielle dans la conception et la mise en œuvre des politiques de contrôle du tabac au Togo.

Si vous souhaitez recevoir une retro-information de cette étude, nous allons noter vos contacts séparément sur un autre papier et pourront vous envoyer les résultats de l'étude dès qu'elle sera achevée dans 3 ans.

Ethique

Cette étude a été approuvée en Afrique du Sud par le Comité d'Ethique de la Faculté des Sciences de la Santé de l'Université de Pretoria, et au Togo par le Comité de Bioéthique pour la Recherché en Santé (CBRS) du Ministère de la Santé Publique. Vous avez le droit de poser des questions et je suis disposé à répondre à toutes vos questions sur cette étude. Si vous avez d'autres questions sur l'étude ou les résultats, sur vos droits en tant que participant à cette étude, ou des préoccupations ou plaintes à propos de cette étude, vous pouvez contacter Dr. Saliyou Sanni, à l'Université de Pretoria par e-mail (u15023363@tuks.co.za & sasanni@yahoo.fr) ou le secrétariat du CRBS à + 228 9020 6221.

Quand participer

Si vous êtes intéressés à participer à cette étude nous allons vous téléphoner pour convenir d'une date pour l'interview. Si vous choisissez de participer à l'interview, il vous sera demandé de remplir et signer une fiche de consentement écrit qui vous sera remise avant le début de l'interview.

Merci pour votre importante contribution à notre étude. Si vous avez des questions ou voudriez avoir des compléments d'informations, n'hésitez pas SVP à me contacter à l'adresse ci-dessous.

Cordialement,

Dr. Saliyou Sanni
Doctorant en Systèmes de Santé
Université de Pretoria
Cel: +228 9005-3261
Email: u15023363@tuks.co.za or sasanni@yahoo.fr

Université de Pretoria
Faculté des Sciences de la Santé
Ecole des Systèmes de Santé et de la Santé Publique

Intitulé de l'étude: Evaluation de l'utilisation de l'Approche Multisectorielle (AMS) dans les politiques de prévention des Maladies Non Transmissibles (MNT): études de cas sur les politiques de contrôle du tabac au Togo et en Afrique du Sud de 2014 à 2016.

Consentement du participant :

Numéro du code du participant…….

J'ai compris avec satisfaction les informations sur l'étude et sur ma participation à ce projet de recherche.

J' (SVP *écrivez en majuscule votre nom*): _____, accepte de participer à la dite recherche.

J'accepte que mon interview soit enregistrée:□ Oui □ No

J'accepte d'être cité: □ Oui □ No

Signature du participant : _____ Date: _____

Signature du Chercheur :_____ Date: _____

Signature du Témoin : _____ Date: _____

Appendix 3: University of Pretoria Ethics Committee approval letter

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

26/11/2015

Approval Certificate
New Application

Ethics Reference No.: 552/2015

Title: Assessment of the Multisectoral Approach (MSA) to Non-Communicable Disease (NCD) Prevention Policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016

Dear Dr Saliyou Sanni

The **New Application** as supported by documents specified in your cover letter dated 17/11/2015 for your research received on the 19/11/2015, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 25/11/2015.

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years
- Please remember to use your protocol number (**552/2015**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

012 354 1677 0866516047 deepeka.behari@up.ac.za http://www.healthethics-up.co.za
Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

Appendix 4: **Proof of article acceptance**

Jennifer Wisdom <Jennifer.Wisdom@sph.cuny.edu>

À :sasanni@yahoo.fr,lekan.ayo-yusuf@smu.ac.za,CHongoro@hsrc.ac.za

29 janv. à 19:39

Hi Co-authors,

I have resubmitted the manuscript as requested by the editors. The only change requested was to make the abstract unstructured (a paragraph) instead of structured. A PDF of the resubmission is attached.

Here is the citation if you would like to update your CVs:

Sanni S, Wisdom JP, Ayo-Yusuf OA, Hongoro. (in press). Multi-sectoral approach to non-communicable disease prevention policy in Sub-Saharan Africa: a conceptual framework for analysis. International Journal of Health Services.

Congratulations to all!
Jen

Jennifer Wisdom, PhD MPH
Director, Center for Innovation in Mental Health
Professor, Health Policy and Management
Graduate School of Public Health and Health Policy
City University of New York
e: jennifer.wisdom@sph.cuny.edu
skype: jenwisdom

From: International Journal of Health Services <onbehalfof@manuscriptcentral.com>
Sent: Monday, January 29, 2018 1:35 PM
To: sasanni@yahoo.fr; Jennifer Wisdom; lekan.ayo-yusuf@smu.ac.za; CHongoro@hsrc.ac.za
Subject: International Journal of Health Services - Manuscript ID IJHS-17-0196.R2

29-Jan-2018

Dear Dr. Wisdom:

Your manuscript entitled "Multi-sectoral approach to non-communicable disease prevention policy in Sub-Saharan Africa: A conceptual framework for analysis" has been successfully submitted online and is presently being given full consideration for publication in International Journal of Health Services.

Your manuscript ID is IJHS-17-0196.R2.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your street address or e-mail address, please log in to ScholarOne Manuscripts at https://mc.manuscriptcentral.com/ijhs and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Center after logging in to https://mc.manuscriptcentral.com/ijhs.

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID (https://orcid.org/). We encourage all authors and co-authors to use ORCID iDs during the peer review process. If you already have an ORCID iD you can link this to your account in ScholarOne just by logging in and editing your account information. If you do not already have an ORCID iD you may login to your ScholarOne account to create your unique identifier and automatically add it to your profile.

Thank you for submitting your manuscript to International Journal of Health Services.

Sincerely,
International Journal of Health Services Editorial Office

UpdatedFinalResubmission_1-29-18.pdf382.8kB

Appendix 5: Curriculum Vitae

In his thesis, Assessment of the multi-sectoral approach (MSA) to non-communicable disease (NCD) prevention policies: case studies on tobacco control policies in Togo and in South Africa from 2014 to 2016, the promovendus aimed to assess NCD prevention policies related to the World Health Organization (WHO) recommended "best-buy" interventions and to investigate the use of MSA in formulating and implementing tobacco control policies. He used mixed methods and developed a comprehensive framework for multisectoaral approach to health policy analysis to analyse study data. The framework is built around four major constructs of context, content, stakeholders and strategies. Study results indicate that tobacco control policies exist in South Africa and Togo and incorporation of multiple stakeholders allowed both countries to formulate policies to meet the WHO Framework Convention on Tobacco Control' goals for tobacco control and NCD reduction. However, these policies were formulated and implemented from an inter-sectoral approach perspective, which relies heavily on information sharing between the health sector and other sectors within and outside the government, and less on collaborative problem-solving. The study recommend to move from an inter-sectoral action for health led by the Health Department to a multi-sectoral approach-whole of government-to health, managed by a national multi-sectoral mechanism at the cabinet level, which will ultimately improve policy coherence across government and yield significant progress toward sound formulation and implementation of comprehensive NCD prevention policies.

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